

ANZSPM

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EDITORIAL

Greetings from your new editor,

Since my name was circulated as "editor" of the ANZSPM newsletter, my e-mail in-box has been inundated with advertisements for Viagra, offers of cheap drugs and the augmentation of a wide variety of organs, many of which I don't possess. Moreover, in the hospital environment in which I work, terms such as "breast" and "Viagra" can't be filtered out as they may well be of genuine medical interest. Such is the lot of an editor. I am told I shall just have to learn to live with it.

I would much rather be inundated with suggestions from ANZSPM members for articles to be included in the next newsletter. I am advised that this is unlikely to happen but one remains hopeful. I appreciate how busy we all are as clinicians, but would encourage readers to let me know if there is something/anything you think should be included. Thanks to Graham Hughes who has provided two pieces of reflective writing to be published in this and the next edition of the newsletter. As in the past, it would be encouraging to think that the newsletter was a "good read", reporting on items of interest in the palliative care world, informing of any policy changes or new developments, as well as being a forum for advertising job vacancies, up and coming conferences, and/or educational events. Anything would be a welcome respite from cheap and dubious drug offers!

In this edition, our President reports on developments in our relationship with PCA. We have an update from Will Cairns on the current status regarding the application for specialty status for palliative medicine. Many thanks to Will for taking this forward. Make sure you read his article right through to the end. Will has donated a prize in a competition that seems to have absolutely nothing to do with palliative care but is to be fully supported anyway and judged by me. If no-one else enters, I score the bottle of bubbly. Odette Spruyt has read and reports on the new trainee curriculum. Willie Landman reports from over the pond and we have two articles on national projects run out of the Centre for Palliative Care Research and Education here in Brisbane. Apologies if I have failed to list any major meetings or conferences in the conference update. Please let me know and I will include them next time.

Janet Hardy
Brisbane, March 2005

PRESIDENT'S SOAPBOX

In the April 2004 issue (volume 13, number 1), past president Michael Ashby announced that ANZSPM had been granted full representation on Palliative Care Australia (PCA), having been an affiliate prior to that. Having attended my first PCA Council meeting in Sydney at the end of last year, it may be timely to report to you on PCA and its activities a little more fully. As most of you know, PCA is the new name for the Australian Association of Hospice and Palliative Care, and as such is the peak body for the state palliative care associations. Its other full members are each of the state and territory organisations. The Cancer Council of Australia is the other affiliate member. PCA has a mission statement which states that it aims to achieve "world's best palliative care" for all Australian citizens through advocacy and setting high standards for practice, policy research and service to the community. It has five strategic aims:

- Improve equity and access to palliative care across Australia
- Improve the quality of palliative care in Australia
- Re-affirm that death is a natural part of life
- Meet the needs of PCA's members
- Create a strong organisation producing an independent voice on palliative care issues

Because ANZSPM is based in Canberra, is a peak body and has a clear advocacy role, it has a lot of power to effect change. Clearly many of its aims and objectives are the same as ANZSPM's and it makes sense in terms of efficiency and efficacy for ANZSPM to be a full part of PCA. Obtaining full memberships, and therefore voting rights, has been a big achievement for our Society. However it also brings with it a responsibility to make sure that PCA pursues activities that fit with our objectives. In particular, we have been asked to sign a Memorandum of Understanding with PCA that all full members have been asked to sign. It mainly relates to fund raising, but contains some clauses that are really only relevant to the state associations and would be contrary to our best interests (e.g. not to contact international groups directly). Further discussion between council and the PCA on this document are underway. I will endeavour to report back what I can from the PCA meetings. The next one is in Canberra on March 30/April 1 but I am unable to attend. Greg Crawford

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and David Woods are currently on the PCA council representing their own states and can also speak for our Society on any issues of relevance. The PCA website is www.pallcare.org.au. In the next newsletter, I will report to you about our relationship with the chapter of palliative medicine.

Paul Glare
Sydney

Report to ANZSPM on the Recognition Process for Specialist Palliative Medicine

After more than two years of work, the Application for the recognition of the specialty of Palliative Medicine is now with the AMC for decision.

Over the past year we have had a number of meetings and discussions following the submission of the final version of our Application in March 2004. The AMC wished clarification on a number of issues. They were concerned about the economic impact of the recognition of the specialty, the impact on General Practitioners wishing to provide palliative care, and our ability to provide adequate numbers of suitable training positions for our trainees. They were particularly interested in further explanation of the nature of the practice of specialist Palliative Medicine and how we saw our specialty developing in the future. In November 2004 we met in Sydney with a sub-committee of the AMC to discuss these issues and followed up in January with a long discussion paper addressing the fourteen written questions they had posed to us.

Our final meeting with the Review Committee of the AMC was held in Melbourne on February 7th. Our delegation consisted of representatives from the Chapter of Palliative Medicine, the Chapter Training Committee, the SAC in Palliative Medicine, Palliative Medicine Trainees, the RACP administration and senior specialists. And a very dignified event it was too. We spent the morning addressing a series of questions they had for us on a wide range of issues. This meeting was followed with site visits by the Review Committee to a range of palliative care centres in Victoria and NSW. Particular thanks to those who participated – their enthusiasm and commitment was greatly appreciated by the Review Committee.

The Review Committee now go off to consider the application. They should have a draft recommendation prepared by the end of April about which we will have the opportunity to comment. The AMC will consider the question at their meeting in July and hopefully make a recommendation to the Minister at that time. Then it will be up to the Minister to decide whether to recognise the Specialty of Palliative Medicine.

In the meantime, the AMC has completed its Accreditation

Report: The Education and Training Programs of the RACP. Starting over two years ago the RACP, including the Chapter of Palliative Medicine, prepared submissions for the AMC regarding our training and CPD programs. The development of our Curriculum and Syllabus was a very important part of this process. In August last year the Specialist Education Accreditation Committee conducted site visits and extensive meetings with the College and most of its components, including Chapter and SAC representatives. The Committee was very complimentary of the Curriculum of the Chapter and SAC. The AMC has accredited training under the SAC in Palliative Medicine as part of the whole of College accreditation of training for FRACP. The Committee did not accredit the training program of the Chapter because the AMC is required to follow the sequence: Part 1 Recognition of Specialty, Part 2 Accreditation of Training. If the Minister approves the Recognition of the Specialty we will the go back go to the AMC for the Accreditation of the Chapter training program. I am hopeful that this will not be too long a process as the advanced training program has already been reviewed and, using the same Curriculum, is virtually identical with that of the SAC which has been accredited.

While this may seem a long-winded and tedious process, it is not as long as it would have been were the RACP as a whole not the subject of Accreditation. If that had been the case then we would have had to wait until the Minister recognised the specialty before any work could be done on Accreditation of training! Perhaps I sound a bit like the end of The Life of Brian.

We will keep you up to date with further developments as we move into the fourth leg of the Hawaiian Ironman Triathlon. A bottle of Australian sparkling white wine to the person with the best suggestion as to the sports modality for the fourth leg – I have my own suggestion which I have confided to the Editor who will be the final arbiter.

Will Cairns
Townsville

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TRAINING CURRICULUM FOR PALLIATIVE MEDICINE

The recently distributed curriculum for Specialists training in Palliative Medicine (January 2005) sets out the requirements for training as they pertain to trainees, their supervisors and the Chapter of Palliative Medicine and Specialist Advisory Committee (SAC), RACP.

I would like to offer some reflections on this development, from the perspective of a supervisor who trained via the College of Physicians SAC approximately 10 years ago.

Firstly, I applaud the working group for adapting the Canadian Medical Education Direction for Specialists (CanMEDS 2000) roles and using these to frame the training program for palliative medicine, thus avoiding unnecessary efforts to reinvent the wheel. It provides a good model to trainees who, in their future careers, will be faced with establishing clinical guidelines and administrative policies, many of which can be adapted from the work of others. Much thought has gone into applying these roles to the palliative medicine doctor and describing the specifics of knowledge, skills and attitudes expected of specialists in Australia and New Zealand.

As a supervisor, I found the document to be both very informative and challenging. It outlines the high standard expected of supervisors including the level of professionalism. The document contains an excellent overview of the various types of supervision; educational, clinical and professional - and also discusses how these differ from mentoring. This has prompted me to read the Hawkins and Shohet textbook cited in the curriculum and to be mindful of the place of clinical/professional supervision personally. A common working environment for palliative care practitioners seems to be one where workloads are excessive and demanding on all fronts - clinical, managerial, administrative and developmental. Such working conditions as we know are the stuff of burnout. Professional supervision and support would seem essential and yet often ignored by many of us.

To digress by way of illustration, I was struck by two job advertisements for Palliative Medicine consultant/director posts recently circulated via ANZSPM email. These jobs, from two states in Australia had allocated sessions that fell markedly below the benchmarks suggested by PCA and markedly short of those required to fulfil the stated job description! Does ANZSPM have a specific role here in advocating on behalf of its membership? For example, could ANZSPM provide independent feedback to the advertising CEOs/HR departments on best practice in palliative care service provision and staffing levels?

Back to the curriculum. The second point I would emphasise is the clarity of information about what is expected and the well defined steps required to achieve successful training. As a trainee, I recall being more focussed on the nitty gritty of the process ie completing prospective application forms in time, determining which projects were required etc, without much

sense of overall direction. Supervision was limited in a fledgling speciality area still finding its feet. Now, as a supervisor, with these guidelines, I would be optimistic that I can help trainees develop as a specialist along broader lines addressing what they hope to achieve, what sort of palliative medicine doctor they wish to become and to have the confidence to develop their personal style of practice.

The importance of comprehensive training of supervisors was stressed when our team discussed the curriculum recently. The feedback on the supervisors workshops offered by the RACP was that the focus was almost exclusively on the assessment rather than the development of trainees. Perhaps a future role for the Chapter/SAC within the College might be one of leadership in these workshops for supervisors for all specialties.

The Personal Learning Portfolio (PLP) promises to be an excellent aid to trainees. It gives responsibility back to them, requiring reflection in the early days of training on their aims and plans for their education in palliative medicine, infusing the development of the plan with their hopes and possibilities for their own future. These plans are then revisited regularly and discussed and clarified with maturing attitudes and expectations.

Thirdly, I raise the ongoing issue of making this training available in all States around Australia. In Victoria, we continue to have problems providing a 6 month community attachment to trainees as no such designated registrar post exists as yet. In other areas of the country, it may be difficult to provide the trainee with 2 palliative care specialists to supervise the first 18 months of training as is now required. Likewise, finding medical or radiation oncology posts will also be difficult for trainees in some areas. The curriculum document stresses that trainees need to be prepared to move about in order to satisfy training requirements. While I strongly support people having a breadth of experience and exposure to palliative care practice during their apprenticeship years, we need to recognise that some will have more difficulty than others and to move interstate to do may be prohibitive. Does the Chapter/SAC have measures available to make the program flexible enough to meet the particular needs of some trainees?

There are a few minor points that I would like clarified. I was unclear about the four mandatory modules and how trainees should find out about these. I also found it difficult to access the appendices which were not enclosed on line, did others?

Finally, a word of thanks to the working group for their excellent work on our behalf. I think this curriculum will be of great practical assistance to me in my role as clinical and educational supervisor and of course, for the trainees themselves.

Odette Spruyt
Melbourne

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Program of Experience in the Palliative Approach (PEPA)

The Program of Experience in the Palliative Approach (PEPA) commenced in all states and territories in 2003 as an initiative of the Australian Government Department of Health and Ageing's National Palliative Care Program. PEPA was developed to meet the growing demand for a health workforce that is informed and committed to the benefits of the palliative approach to care for people with life-limiting disease and their families.

PEPA has three components:

- A supervised clinical attachment with a specialist palliative care service that provides participants with hands on clinical experience
- Following the attachment, the PEPA participant is expected to undertake a quality activity in their own workplace to enhance patient and family outcomes
- Post-placement support is provided for participants so that learning is integrated into their own work setting.

To date, over 200 nurses and allied health, including those from rural and remote areas, have participated in PEPA placements. In 2005, PEPA is being offered to general practitioners, medical specialists and rural and remote medical staff.

Through the evaluation process, health care professionals are reporting improved confidence and ability in caring for people who have palliative needs and their families. Many host sites have reported that the PEPA experience is beneficial and that they will continue to make links with participants after their placements are completed. PEPA has resulted in many quality improvement activities including the fine tuning of referral processes and greater participant understanding of the care of people at the end of life.

For further information regarding PEPA please go to www.cpcrc.com.

Gordon Poulton
CPCRC

Australian Best Care of the Dying (ABCD) Network Project

Most Australians die in hospital and there is evidence to suggest that the care of these patients is not always optimal. Late implementation of end-of-life management plans and active treatment up to and including the day of death have been well described and may be common place. Death is seen as a failure within many medical models. As a consequence, many patients still die alone, frightened and without dignity, having lost all control, feeling abandoned by health care professionals. The way a patient dies remains as a lasting memory for those relatives and carers left behind and is becoming a common cause of complaint within hospitals.

The CPCRC and a network of six hospitals and institutions in Brisbane has been successful in an application to the National Institute of Clinical Studies (NICS) for funding for a project designed to improve the care of patients dying throughout Australia via a care pathway program - the Australian Best Care of the Dying (ABCD) Project.

The principal aim of the project is to extend the excellence of care of the dying provided in hospices to other settings such as acute hospitals, hospices, nursing homes and the community within a network model.

The first phase of the ABCD project involves a retrospective audit of at least 20 patient charts at each site involved in the project. The audit is designed to assess the degree to which documentation of terminal care meets the criteria of a "good death". This base review identifies any gaps in the quality of

care of the dying that can then be addressed following the introduction of a care pathway program as the second phase of the project.

Care pathways are locally agreed multidisciplinary evidence-based practice guidelines for specific patient/user groups. Care pathways for the dying were first developed by a specialist palliative care team in Liverpool, UK and now form part of standard management in over one hundred UK hospitals. The Liverpool Care Pathway (LCP) defines goals considered essential in the management of dying patients and for the care of their relatives/carers after death. These include initial assessment and care goals as well as care after death goals. The pathway also incorporates an assessment of on-going care for patients on the pathway.

The project is led by Assoc. Prof. Janet Hardy, through the CPCRC in Brisbane and has recently expanded to include the Gordonvale Unit in Cairns. The focus of the ABCD network is to implement the LCP into key hospitals within the Brisbane area with the eventual aim of expanding the network to include any hospital or institution in Australia expressing an interest in using this tool to improve the care of the dying. A data base of all units interested, or partaking in an end-stage care pathway project throughout Australia has been formed. If any unit is interested in registering their unit on the data base, please contact **Janet Hardy** or **John Haberecht** (lead project officer) through the CPCRC (cpcrc@health.qld.gov.au).

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New Zealand News

We have had a GREAT summer in New Zealand and now it seems as though the rugby Super 12 developments are pointing to a great winter for New Zealand as well!

The year has been moving along at a very brisk pace up here in the Big Smoke, but a lot of the action in the Palliative care world seems to have come from down Wellington way. This is unsurprising, since both the Ministry and Hospice NZ find themselves there.

However, before getting to the business end of things, some personal news from around the country. We would like to convey our heartiest congratulations to our executive member Dawn White following the arrival of her daughter Harriet "Hettie" on the 21st of March; Mom, Dad and baby all well. Kate Grundy is progressing well towards her big event down in Christchurch. Although we seem to be heading for some difficulties with shortages of Palliative Medicine specialists, there has been some movement around the country with Joy Percy joining the strong Palmerston North team as a locum, Alan Farnell moving to Waikato in the place of Rob Jaffrey and the team at North Shore hospice/hospital being strengthened soon.

Now the business!

Trans-Tasman ANZSPM affairs: An interesting document of understanding between Palliative Care Australia (PCA) and its constituent members about authority, roles and responsibilities may well illustrate the future of palliative care in New Zealand. Joy Percy and I attended a meeting in Wellington initiated and facilitated by Simon Allen, of stakeholder groups involved in the provision of Palliative Care in NZ. Unfortunately, not all invited groups could send a representative to the meeting. The purpose of the meeting was to clarify how the groups saw the future of palliative care in NZ and whether there was a need for an umbrella organisation/group representing all stakeholders in palliative care in New Zealand. The meeting was hosted by Hospice NZ and an interesting discussion led to planning a follow-up meeting at the end of April, hopefully with better representation from all the groups involved, especially from primary care. The view of many is that, until an umbrella organization is established, the Palliative Care Subgroup of the NZ Cancer Treatment Working Party should fulfill this planning function (this group has wide representation from all PC providers). Ann MacLennan has been our very able representative on this group, and has also been the author of a letter of comment to the Chair of the Cancer Control Taskforce reinforcing the importance of Palliative Care services as a key stakeholder in the Cancer Control Action Plan. Anne also pointed to the current workforce stresses in Palliative Care that requires planning and development, and which should be integrated in the Cancer control strategy. The point is also

raised that much Palliative Care service development is in the area of the non-cancer population.

ANZSPM conference: This has been finalised and booked for the 23rd to 25th of June, and will be a joint meeting with the Hospital Palliative Care New Zealand (HPCNZ) group. The meeting will be held at Capital House (www.capitalhouse.co.nz) in Wellington. The proposed program will be:

Thursday: morning: - HPCNZ meeting
afternoon: - Palliative Care Nurses forum
- ANZSPM informal meeting with news from the regions

Friday: All day combined meeting with updates on research, conferences and items of mutual interest.

Saturday: ANZSPM AGM

We are (AS USUAL!) asking for topics of interest and volunteers to step forward for the Friday program. Jean Clarke from Palmerston North is going to talk on her experience of getting the Liverpool Care of the Dying Pathway going in both hospital and hospice settings, and we (the attendees at the Montreal Conference) will do an update/report.

The camaraderie at these meetings has been great, and we are hoping to have an active social program to keep this going-watch this space! Joy Percy will be chasing you up for registrations- come and have fun and recharge your batteries.

Willie Landman
Auckland, NZ



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Changing Gears in Palliative Care

I recently bought a new 27 speed road bicycle, and have been burning up the kilometres around the Adelaide Hills. This has been a new experience for me, with new difficulties and dangers not previously encountered.

On one occasion, as I started struggling up a hill and was too slow to change gears, it struck me that there was an odd similarity between my predicament on the bike at that moment, and planning the care of a palliative care patient in an unstable, declining phase of their illness.

To illustrate this analogy, (you may be scratching your heads!), consider the following scenario. Your patient is at home with a carer (wife), and a capable extended family support. He is declining, but just able to swallow his slow release morphine and metoclopramide. He is not eating at all, and is taking a small amount of fluid only. His main distress is his urinary retention, with incontinence, which disturbs him greatly. He becomes agitated and confused when his bladder is full, and is embarrassed when his bladder empties. His wife gives him an occasional diazepam when he is agitated. It is Thursday lunch time, and you are visiting him at home, having not seen him for a week. You clearly see the significant decline in that time.

It is time to change gear. A steep hill approaches. On my bike, it seems easier to change gear at the start of the hill. If I wait until the going is really tough, then it is harder to make the change, and the transition is not smooth. It is the same with this patient. Steps can be put in place now that will allow a smooth transition as the hill steepens (usually on the weekend!). Waiting for the inevitable steepening of the hill as he declines without an anticipatory gear change will cause a much more difficult situation for all concerned.

In the above scenario the following steps can be made:

- Offer urinary catheterization.
- Write prescriptions for parenteral morphine and metoclopramide, for the family to pick up and have in the home as standby.
- Write a prescription for a parenteral benzodiazepine eg clonazepam, if needed for his agitation/confusion.
- Write flexible drug orders for the community nurses in case a syringe driver is needed. (see footnote below)
- Discuss with the patient's wife and family the emergency options available over the weekend, ie who to call, wishes for place of death etc.

Integral to this gear change being effective is a call to the community nursing service. This will result in:

- a catheter and insertion pack being taken to the home.
- syringes being delivered with instructions for the family re how to give breakthrough doses if needed.
- the insertion of a subcutaneous line to be used if needed.
- The delivery of a syringe driver to the house for use if needed.
- an arrangement for daily nursing visits over the weekend (and the setting up of the syringe driver if needed).

Having put these changes in place, you can be comfortable that if the patient's condition deteriorates, and he can no longer swallow, good analgesic, antiemetic, and anxiolytic treatment can continue, with good nursing support. You have effectively changed gear more easily than you could have if the hill had become steeper and you were unprepared (for example, a midnight call on Saturday night, precipitated by urinary retention and inadequate analgesia).

The unexpected can always occur, both in palliative care and on the bike, but as a general principle, if you see the hill, and begin to feel the slope, then change gears early and prepare for the next part of the journey.

Graham Hughes
South Australia

Footnote

If your patient was on 60 mg oral sustained release morphine, a flexible drug order would read, for example

Morphine 20-35mg s/c via syringe driver in 24hours
and

Morphine 5-7.5mg s/c prn for breakthrough pain

This gives the community nurse some flexibility to adjust the dose according to the patient's condition, and gives you the option to set boundaries beyond which you wish to be notified.

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Conference Update

<p>Evidence Based Medicine Workshop</p> <p>9am—1.30pm (including lunch)</p> <p>Townsville Hospital, Douglas</p> <p>Saturday 30 April</p> <p>Jwasiak@ranzcog.edu.au or ph: 03 9412 2959</p>	<p>11th IASP World Congress on Pain</p> <p>Official satellite symposia</p> <p>17-20 August and 27 August-3 September</p> <p>www.iasp-pain.org/05satellitesymp.html</p>
<p>Centre for Palliative Care Research and Education</p> <p>4th Annual Research Conference</p> <p>Brisbane 4 June 2005</p> <p>www.cpre.com/</p>	<p>Tackling under-treated pain : breaking down the barriers</p> <p>National Institute of Clinical Studies one-day conference</p> <p>Intercontinental Hotel Sydney, 20 August</p> <p>www.tacklingpain.com.au</p>
<p>Joint meeting of ANZSPM and Hospital Palliative Care New Zealand (HPCNZ)</p> <p>Wellington, 23-25 June 2005</p>	<p>New Horizons</p> <p>8th Australian Palliative Care Conference</p> <p>Sydney, 30 August – 2 September 2005</p> <p>www.pallcare.org.au</p>
<p>11th IASP World Congress on Pain</p> <p>Sydney, 21-26 August 2005</p> <p>www.iasp-pain.org/05Cong.html</p>	<p>International Institute of Palliative and Supportive Studies</p> <p>2nd Annual South Australian Palliative care Update</p> <p>30 September 2005</p>

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