

# ANZSPM

n e w s l e t t e r



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## EDITORIAL

Preparations for the 2002 ANZSPM Conference in September are well advanced. You should receive hard-copy advice soon and should be considering negotiating leave from regular commitments. This conference promises to be yet another success. Unfortunately Ann Goldman, Paediatric Palliative Care Specialist from Great Ormond Street is unable to attend for family reasons. We hope to be able to announce the confirmed line up of Guest Speakers soon.

I would encourage you all to consider your role in relationship to ANZSPM Council. Elections will be held in Townsville at the AGM. We currently do not have a member of Council who practices Palliative Medicine as part of another area of medicine - i.e. who does not work exclusively in Palliative Medicine. Will Cairns has clearly articulated that he will not be standing for re-election as President and there may well be other vacancies. Now is your opportunity to "have your say."

In Letters to the Editor there is continuing debate about euthanasia and assisted suicide - and a book review about the complexity of decision-making at the end of life. Also in this edition find information about educational opportunities and employment.

I would like to acknowledge our new sponsors Mundipharma Pty Ltd. We are very grateful for their willingness to support our Society.

I look forward to seeing many of you in Townsville.

Best wishes,  
Greg Crawford  
Adelaide  
July 2002

## PRESIDENT'S SOAPBOX

The icy blasts of winter have finally arrived pushing the North Queensland temperatures down into the mid 20's, and even below 15 at night. Sometimes it is hard to believe that the complexities of our social existence can break through into consciousness in the face of such glorious weather.

I am sure that the events of the last few of months have caused many of us to consider the ways that we deal with enquiries about, and requests for, euthanasia. The complexity of the issues for a diverse society and the confusion within our community has not diminished with time. This is evident over recent weeks in the diversity of comment in the media about end of life issues and palliative care.

Last year I sat down in front of my computer to set down my own thoughts on palliative care, and where it is that we fit into the provision of end of life care. The result is rather long winded but meets my needs, and is printed elsewhere (see pages 10 & 11) in the Newsletter. I felt that it was crucial for me, and for the community that I serve, that I clarify for myself what it is that I do and do not do in my role as a practitioner of palliative medicine. I did not aim to set down my attitudes to euthanasia because they are outside the set of duties that define my role as a palliative medicine specialist. When a patient comes to me for palliative care both they and I should know what it is that I can provide for them, and what I will be unable to provide. This is crucial for patients and their families, as they should not be deterred from seeking our help by unfounded fears for what we might do to them or refuse to provide for them. And the core activities of palliative care will remain the same, irrespective of any future changes to legislation with regard to end of life issues.

The membership of ANZSPM holds, and sometimes expresses, opinions across the full spectrum of attitudes to euthanasia and other end of life issues. While we do bring our somewhat unique experience when we do so, and have an important contribution to make to the debate, our comments will always be heavily influenced by our underlying personal value systems, and spiritual and religious beliefs.

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*(Continued from page 1)*

However, we need not hold any specific set of beliefs about euthanasia in order to practice palliative medicine in a competent manner. I think of Venn diagrams where the boundaries of palliative care and palliative medicine do not intersect with those around my beliefs on euthanasia, about which my patients need know nothing.

I believe that we owe a responsibility to palliative medicine to ensure that our pronouncements on issues outside the sphere of the practice of palliative medicine are identified as such and do not jeopardise the acceptance of our work by the community. We must clearly set out what we do as palliative medicine doctors, stating openly our strengths, weaknesses and uncertainties. The best thing that we can do for our patients and community is provide high quality palliative medicine that encourages people to take advantage of what we have to offer.

One area on which we can perhaps all agree is the need for our society to address end of life care and decision-making. Much of our liaison work is directed to set an example for what we believe to be appropriate management. Most of us will have experienced a progressive cultural change over the past ten years or so. I know of a couple of more formal projects underway around the region to promote appropriate management of people with advanced disease. Roger Woodruff tells me that the Austin and Repatriation Medical Centre in Melbourne have started their "Respecting Patient Choices" Project aimed at improving end of life care. This is an institution wide project based on a successful model developed in Wisconsin. In a separate development ANZSPM, in conjunction with the Chapter of Palliative Medicine and the Health Policy Unit of the RACP, has now moved again on our project to open public debate on these issues. In the US the public and professional debate about end of life issues is far more developed. John Cavenagh recently visited the US to undertake a course on the subject under the auspices of EPEC <http://www.epec.net>. There are any number of web sites you could look at but I found the American Medical Association site <http://www.ama-assn.org/ama/pub/category/2755.html> to be very helpful, along with <http://stills.nap.edu/readingroom/books/approaching/>.

This is one project that I believe that each of us could pursue in our own communities and institutions, and is certainly an important role for ANZSPM to take in the future.

Not so long ago I was interested to see a piece in The Weekend Australian (15-16/6/02) by Ruth Ostrow who addressed the acceptance of mortality.

*"It is the separation from the natural world that distorts reality. We live in a society that immunises us against the truth. Glossy magazines promising happy-ever-after deny aging, deny fallibility. We get an exaggerated view of our own precious importance from the top of tall buildings. Safely bricked in, we believe that it will never happen to us. Without trees, insects and nature to teach us about the sacred cycle of life and death we are lost in the fantasy of immortality....."*

*.....Perhaps when we can understand and accept the perspective on our lives from the eagles eye, we can finally free ourselves from suffering."*

Finally, remember to consider who might nominate for the ANZSPM Council.

I look forward to seeing you in Townsville in late September. Registration forms for the Conference can be downloaded from the web site at [www.conferenceplanners.com.au](http://www.conferenceplanners.com.au) and will soon appear in the post. Have a good winter.

Will Cairns  
Townsville  
July 2002

## PALLIATIVE MEDICINE LOCUM

DARWIN,  
NORTHERN TERRITORY

An opportunity exists for a holder of the FACHPM to spend 4 months (approx) in Darwin & surrounds as a locum in Palliative Medicine.

- Great salary
- Accommodation
- Airfares provided
- Vehicle provided

Dates: October 2002 - March 2003 (some flexibility possible)

Contact: Dr Rob Rayner  
Ph. 08 8985 4761 (h)  
Ph. 08 8922 7004 (w)  
Ph. 0417 876 440 (m)

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## RESPECTING PATIENT CHOICES

**A Pilot Program of Advanced Care Planning at the Austin Repatriation Medical Centre, Melbourne.**

### Project Aim

This project aims to establish a consumer-based, widely accepted and sustainable program of advance care planning at the Austin & Repatriation Medical Centre (A & RMC) and in the surrounding community.

### The Advanced Directive Program in La Crosse, Wisconsin.

The A&RMC pilot project is based on the successful advanced directive program from La Crosse in Wisconsin. In La Crosse, all hospitals, clinics, nursing homes and hospices collaborated to introduce the Respecting Choices® program into the local community. This program, developed and run by their medical education foundation, was first applied to select patient groups in the main teaching hospital, in order to establish staff support, then extended to the rest of the hospital and the community. The Program is now being employed in other states in the USA and has been recognised as "best practice" by The [US] National Coalition on Health Care and The Institute for Healthcare Improvement.

The achievements of the Respecting Choices® Program in La Crosse include:

- 85% of patients who died in hospital had completed a Patient Advance Request (PAR) form (increased from 15% pre-program)
- 96% of PAR forms were available in "the green sleeve" in patient medical records (increased from 4% pre-program)
- The patient's wishes, as stated in the PAR form, were followed in 98% of deaths
- Appointed medical attorneys felt more comfortable with their role
- Deceased patients with a PAR form were 7 fold less likely to die in hospital and 4 fold more likely to have been admitted to a long-term care facility or a hospice prior to death
- Deceased patients without a PAR form were 1.3 times more likely to have been hospitalised in the last 6 months of life and to have cost a median of \$2,000 more in hospital services in the last 6 months of life.

The positive impact of advance care planning discussions on the patient's perception of the quality of care was demonstrated in a randomised trial in Massachusetts, in which the Respecting Choices® program was provided to patients over the age of 65.

### The A&RMC program

The Austin & Repatriation Medical Centre will introduce this program with the title "Respecting Patient Choices". As with the Wisconsin model the program will train targeted nursing and allied health staff and carefully selected volunteers to facilitate patient understanding of advance care planning, and to complete a Patient Advance Request (PAR) form that includes nomination of an enduring medical power of attorney. The program includes educational and promotional materials (e.g., posters, brochures, handouts) that are placed in hospital clinics and doctor's offices.

*Three key steps will be:*

1. using the completion of the PAR form to initiate discussion between the patient, the next-of-kin and the hospital staff regarding end-of-life care;
2. educating medical and other key staff about the program and its relevance to daily clinical practice, and
3. placing a plastic 'green sleeve' containing the Patient Advance Request form in the patient's medical records, ensuring the PAR form goes with the patient and has appropriate impact on end-of-life care when required.

### Further development of the Program

Following implementation and evaluation of the pilot study, the Respecting Patient Choices program will be introduced across the Medical Centre, to other health care facilities in the region, and to the surrounding community. Once established, educational assistance will be provided for the introduction of the Respecting Patient Choices program to other hospitals that show an interest in such a model of change.

### Further information

Contact the Project Officer, Melodie Heland

Tel: 03 9496 5660 or 03 9496 5000, Pager 5660

Melodie.HELAND@armc.org.au

## LETTERS TO THE EDITOR

Dear Sir,

### Nurse Practitioner Positions in Palliative Care

Two palliative care (PC) services in Melbourne are piloting Nurse Practitioner (NP) positions. This has not been widely discussed in PC circles, but raises questions about how we see the optimal delivery of palliative care in the future - its interdisciplinary nature, the role of PC specialists, and what effect (good or bad) the introduction of NPs might have.

The Victorian NP Program is said to be "not about doctor substitution or substitution of medical care", but the stated aim of one of the Melbourne programs is "minimising unnecessary costly interventions by general practitioners and the palliative care physician." The service in question does not employ a palliative care specialist or deem one necessary.

The NPs will be able to prescribe, order pathology and radiology, refer to specialists, and admit and discharge patients.

The questions that need to be discussed in palliative care circles include:

1. Is there a demonstrable need for NPs in PC and, if so, in metropolitan or rural settings or both?

NP positions are deemed necessary to avoid problems that occur with patient care when the doctor is not available, particularly at night and weekends. However, it should be noted that the NPs will only be employed during normal office hours.

The implementation of few simple rules would circumvent the problems, e.g.

- i. no PC patient can be discharged from hospital without a supply of medications and written orders to use them
- ii. scripts can be written by the GP or the PC specialist and faxed to the pharmacy; GPs will have to be taught to take calls from PC nurses promptly

The other reason for advocating for NPs is that senior PC nurses should receive appropriate acknowledgement for their professional experience and skills. This goes without saying, but the question is are NP positions best for the future of PC.

2. What is the role of the PC specialist in the provision of optimal care?

The recently published UK NHS guidelines state that the minimum requirements for a palliative care service are a specialist palliative care nurse and a specialist palliative care doctor. To say that all medical problems can be sorted out by an experienced nurse, without specialist medical back-up, is nonsense and belittles the complexity of palliative medicine.

3. Will NPs in PC lead to the exclusion of GPs?

Much effort has gone into educating GPs about PC and involving them in the care of their patients. However, whatever the initial intention, the NP model (armed with prescribing, referring and admitting rights) will sooner or later lead to the exclusion of the GP.

Doctors may feel alienated or offended if their patient's treatment is changed by a NP without prior consultation. A patient under my care was recently told by a NP that the medications prescribed by his GP and myself were inappropriate, and an offer made to prescribe alternatives; no attempt was made to discuss this with the GP or myself.

4. Will NP positions change how PC is viewed by others?

PC originated as an alternative to orthodox medicine, when little PC was practised in hospitals. That has changed and PC is now a genuine part of mainstream medicine.

The NP model (armed with prescribing, referring and admitting rights) risks that PC might again become regarded as an alternative path, practised by the NPs and not by the doctors.

The implementation of NPs in PC raises important questions - medical, political and financial - about how we see the optimal mode of delivery of palliative care in the future.

These questions deserve wide discussion.

Roger Woodruff FRACP, FACHPM  
Director of Palliative Care,  
Austin & Repatriation Medical Centre, Melbourne

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## LETTERS TO THE EDITOR

*(Continued from page 4)*

Dear Sir,

I wish to pose a few questions to our Society that I have been considering for a long time. I hope that members of ANZSPM can shed some light as I am feeling more and more frustrated and confused as time goes by.

Over the last few years we have seen an escalation in the number of people that pro-euthanasia advocates have 'presented' to the public. These people have been packaged as having a "terminal illness" and are willing to die (with varying degrees of public exposure) by their own hand, in order to illustrate what they believe is an unfair legal situation with respect to euthanasia and assisted suicide. Cases in point include Norma Hall; Nancy Crick; and Sandy Williamson. We are informed by the press that more are 'in the wings.'

Throughout this time I have been increasingly more perplexed about our role in these issues. It seems that as the media coverage of the pro-euthanasia group increases exponentially over time, so too does the anti-euthanasia and palliative care media response decrease exponentially.

Most recently, I attended the National AMA Conference End-of-Life Debate. Two hours of debate barely touched the surface of end-of-life issues. It was obvious that many of our medical/surgical colleagues are ill-informed about the Doctrine of Double Effect; do not understand the concept of Palliative Care, nor it's functional aspects; and believe that morphine kills. From the debate there emerged a frontpage headline in the Sydney Morning Herald (SMH) that has the potential to put Palliative Care back 20 years: "Doctors Cleared to Hasten Death" (SMH 27/5/02). Never mind the fact that "hasten death" is a euthanasia euphemism, this headline sentiment was NOT what was decided in the motions accepted by the AMA.

Now we discover that Nancy Crick did not have cancer; that "unrelenting suffering" should be in the guidelines put up for legislation rather than "terminal illness" that "palliative care does not work" (Dr Phillip Nitschke, Lateline); and that for Dr Nitschke, Nancy Crick "was a friend ....., and a pretty close friend..." (1/6/02 Daily Telegraph).

The questions I pose to ANZSPM are:

1. Have we been conspicuous by our absence in the Australian media?
2. Is there an unwritten rule (that I am not privy to) that (e.g) "Anti-euthanasia comment should only come from organisations such as PCA or the ANZSPM" rather than from individuals?
3. Are we too "nice"..... or too "scared" to let our voices be heard?
4. Is palliative care poor media fodder?
5. Is there a conspiracy in the media to exclude our social commentary on the euthanasia debate?

I would be grateful for ALL of your comments and thoughts.

With great respect,  
Susan Newton

Dear Sir,

Members may be interested to know that transmucosal fentanyl citrate lozenges are being made available in Australia by Orphan Australia for the treatment of breakthrough pain for people on opioids.

Orphan Australia advises that while they intend to register the lozenges, they are currently only available through the Special Access Scheme (SAS). Although there are extra forms that need to be filled out to access these medications, they fill a niche for another community-friendly breakthrough medication for people on opioids. Prescribing them is different to other breakthrough, and training is available or contact can be made with clinicians around the country who have experience with them.

To obtain further information on the lozenges and how to obtain them, please contact Orphan Australia directly on 03 9769 5744 or 1300 656 755 or email [info@orphan.com.au](mailto:info@orphan.com.au)

Yours sincerely,  
David Currow

Professor of Palliative & Supportive Services  
Flinders University, Adelaide.

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## LETTERS TO THE EDITOR

Dear Editor,

The Chapter of Palliative Medicine has recently adopted the Internal Medicine Journal as its official journal.

I wish to inform the Membership that I have been nominated as the Palliative Medicine Sub-Editor to the Internal Medicine Journal, a role that I have accepted with pride.

As the Sub-Editor I would like to encourage original contributions in Palliative Medicine to the Journal. Our involvement in the Journal via contribution cements our position as a vibrant, fresh and new specialty, both locally and globally.

My role will require the assistance of my colleagues to review and referee journal articles of interest in Palliative Medicine. I would be delighted to hear from those in our Chapter willing to offer their skills and time as referees. I can be contacted by email: [quesera@comcen.com.au](mailto:quesera@comcen.com.au)

I look forward to the contributions!

Sincerely,

Susan Newton

B Med, FACHPM

## LAUGHTER IS GOOD MEDICINE

A man had tickets for the Grand Final soccer match in Yokohama. As he sat down, another man approached him and asked if anyone was sitting in the seat next to him.

"No", he replied. "The seat is empty."

"Well, that's incredible," said the other man. "Who in their right mind would have a seat like this to watch the Germans play Brazil and not use it?"

"Well, actually, the seat belongs to me," the first man replied. "I was supposed to come with my wife, but she died. I have been helped by the Palliative Care Service and they are supporting my in my bereavement. This is the first overseas soccer match my wife and I haven't attended together since we were married.

"Oh I'm sorry to hear that," the other man said. "Couldn't you find someone else, a friend, a relative or even a neighbour to take the seat?"

The first man shook his head sadly and replied: "No. They're all the funeral".

## GLAXO SMITH KLINE

As the former editor of the ANZSPM Newsletter I have been asked to acknowledge the role of GlaxoSmithKline in their generous sponsorship of this Newsletter over many years. I took over the editor's role from Dr Bob Pye at the 1994 Scientific Meeting here in the Hunter. After listening carefully to Bob about how to be an editor, I canvassed membership support for the Newsletter and sat back and waited. As all editors find (I'm sure) it was a lonely isolated existence as weeks passed without any reaction from members about anything. I decided to spend my time improving the appearance of the Newsletter and quickly realised this was an expensive undertaking. The local printer had many other priorities besides our humble Newsletter and getting the Newsletter produced, printed and posted out became increasingly frustrating. I needed some professional help.

In mid 1997 during a conversation with a pharmaceutical representative I floated the idea of financial support for the production and distribution of our Newsletter. It was suggested I contact Glaxo Wellcome Head Office and speak with Clare Jones, Oncology Product Manager at the time, and make a request for some sponsorship of the ANZSPM Newsletter. I did this and was pleasantly surprised by Glaxo's willingness to assist us in getting a quality Newsletter distributed.

Over the ensuing years their support was both generous and without strings. They never sought to interfere in the content and neither did they expect us to give them undue publicity. The only evidence of Glaxo's generosity were the words "Proudly sponsored by Glaxo Australia" at the bottom of each page of the Newsletter. Most importantly they provided expert assistance with publication by putting us in touch with Creative Logic Ltd a Melbourne publication firm. Over the ensuing years the Newsletter production became a very smooth process indeed.

Glaxo have made a major contribution to our Society through their generous support of the Newsletter from 1997 and into the new millennium. As they retire from this sponsorship it is my pleasant task to thank them sincerely on your behalf for their assistance in forwarding the cause of Palliative Medicine in Australia.

John Cavenagh  
Newcastle

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## BOOK REVIEW

### **THE CASE AGAINST ASSISTED SUICIDE: For the right to End-of-Life Care** Kathleen Foley and Herbert Hendin (Eds) John Hopkins University Press, 2002 ISBN 0-80186792-4 371pp RRP: \$US49.95 £33.50

This book sets out the medical, ethical, philosophical and legal arguments against the legalisation of physician-assisted suicide and, just as importantly, describes how palliative care needs to be developed so that we can uphold the right of the terminally ill not to suffer.

In the first section - Autonomy, Compassion and Rational Suicide - Leon Kass, Edmund Pellegrino and Daniel Callaghan argue that neither of the major justifications for assisted suicide, autonomy and compassion, provides an adequate basis for legalising the practice.

The second section - Practice versus Theory - includes chapters on the practice of assisted suicide and euthanasia in The Netherlands, Oregon and the Australian Northern Territory. Hendin's extensive knowledge and insight is evident in the review of the Dutch practices and includes the remarkable statement by one of the authors of the 1995 Dutch report "that the person responsible for avoiding involuntary termination of life is the patient." Ben Zylicz describes working in palliative care in The Netherlands, where its development has been severely hampered by the easy availability of euthanasia. Foley and Hendin review the Oregon experiment and the Northern Territory deaths are discussed by David Kissane.

The third section - Reason to be Concerned - includes chapters by Joanne Lynn, Harvey Chochinov and others discussing assisted suicide and palliative care in relation to patients who are disabled, vulnerable, or depressed.

The last section - A Better Way - includes chapters by Dame Cicely Saunders and Kathleen Foley, examining the state of palliative care and what needs to be done to improve it so that it provides better end-of-life care, for all who need it.

This book provides an open and tolerant discussion of both the case against assisted suicide and the case for palliative care. It also provides some powerful insights into the shortcomings of the palliative care system and how it might be improved. This is an excellent book that will be a valuable resource for anybody interested in the delivery of better end-of-life care, whether they are clinicians, ethicists or health care policy makers.

Roger Woodruff

Director of Palliative Care,  
Austin and Repatriation Medical Centre  
Melbourne

## ANZSPM 2002 CONFERENCE UPDATE

The hiccup caused by the withdrawal of Ann Goldman as a keynote speaker has been cured (if only it was as easy for our patients). Ann very much regrets that she has had to withdraw and hopes to be able to visit Australia again in the future. Dr Gerri Frager from Halifax in Nova Scotia has very kindly agreed to step in at short notice. Her CV is below. We are now able to get on with the printing of the registration material. To compensate for our delay we have extended the early bird period to August 15th. Quite a number of you have already downloaded the relevant material from the Internet and registered for the conference.

We have accepted all the papers that were proposed and the latest draft of the programme is accessible on the website at [www.conferenceplanners.com.au](http://www.conferenceplanners.com.au)

Dr. Gerri Frager is a paediatrician and the Medical Director of the Paediatric Palliative Care Service at the IWK Grace Health Centre in Halifax, Nova Scotia, Canada. She is Assistant Professor at Dalhousie University. Gerri came to this position having explored various models of palliative care delivery through a year-long traveling fellowship covering the US, the UK, and Canada. She then spent 2 1/4 years as a fellow with the Pain Service at Memorial Sloan-Kettering Cancer Centre in New York. Gerri worked as a nurse for 9 years before pursuing her medical degree at McMaster University in Hamilton, Ontario whose model of tutorial based, self-directed learning is being replicated across North America. Dr. Frager is a Faculty Scholar Alumnus with the OSI's Project Death in America, which is committed to the goal of improving care at the end-of-life. Dr. Frager is a frequent presenter at regional, national and international conferences and author of publications relating to Paediatric Palliative Care.

Will Cairns  
Townsville July 21st 2002

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## COMING EVENTS

### ANZSPM 2002 Townsville, Queensland

25 - 28 September 2002

5th Biennial Conference of the Australian &  
New Zealand Society of Palliative

For all Medical Practitioners with an interest in  
palliative medicine wherever it is practiced.

Topics include:

- paediatric palliative medicine,
- communication workshops,
- palliative medicine in general practice

Keynote speakers include:

Dr Peter Maguire, Psychiatrist from Manchester

Open forum discussions, networking, extensive social  
programme in the relaxing warmth of a tropical Spring.

To register your interest in attending and for further  
information, contact:

Conference Planners North Queensland

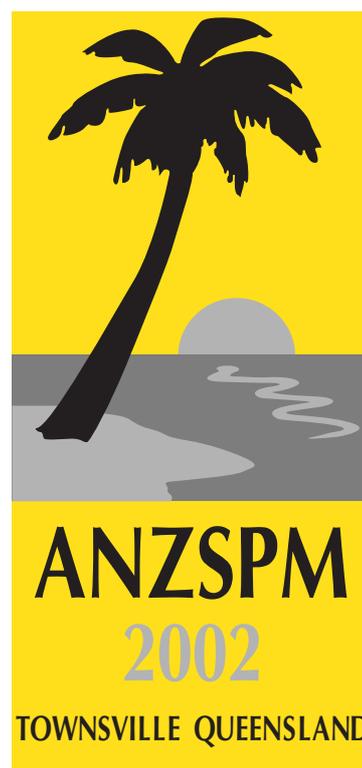
Phone: +61 7 47212377 Fax: +61 7 47214936

Email: [callus@conferenceplanners.com.au](mailto:callus@conferenceplanners.com.au)

PO Box. 771 Townsville, Qld 4810 Australia

350 Flinders Mall, Townsville, Qld 4810 Australia

[www.conferenceplanners.com.au/conferences2002.html](http://www.conferenceplanners.com.au/conferences2002.html)



### AUSTRALIAN PAIN SOCIETY AND NEW ZEALAND PAIN SOCIETY Combined meeting of the Australian Pain Society and New Zealand Pain Society

9 - 13 March 2003

Christchurch Convention Centre Christchurch, New Zealand

[www.apsoc.org.au](http://www.apsoc.org.au)

Theme: A Fresh Approach to Pain Management

Call for abstracts application forms will be available through this website as well as further information and registration.

### 8th CONGRESS OF THE EUROPEAN ASSOCIATION FOR PALLIATIVE CARE

The Hague, The Netherlands

April 2 - 5, 2003

<http://www.eapcnet.org/TheHague2003/>

Sponsored by Mundipharma Pty Ltd

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## JOB VACANCY

**Director of Palliative Care Clinical Services (full time)**  
Sisters of Charity Health Service, Melbourne

## DIRECTOR OF PALLIATIVE CARE CLINICAL SERVICES

eastern palliative care

A community based palliative care agency.



Sisters of Charity  
Health Service  
MELBOURNE

Incorporating Caritas Christi Hospice,  
St. Vincent's Hospital, Melbourne  
and St. George's Health Service.

easternhealth

Box Hill Hospital, Peter James Centre, Angliss  
Hospital, Maroondah Hospital, Yarra Ranges  
Health Services, and Healesville Hospital.

The Sisters of Charity Health Service (SCHS) currently operates an extensive range of palliative care services, serving the Eastern and Northern regions of metropolitan Melbourne. These include 58 hospice beds, located currently at Fitzroy and Kew, Day Hospice services, a collaborative alliance in a community/home based palliative care service (Eastern Palliative Care) and consultative services to acute health units. It is proposed to relocate some of the hospice beds to a site to be operated in collaboration with Eastern Health, which currently has no formal palliative care services.

SCHS currently has 4 part-time senior medical staff in palliative care and hosts the Centre for Palliative Care, an academic unit focusing on research and post-graduate training in palliative medicine and psycho-oncology.

A dynamic and innovative clinician is sought to lead and remodel the clinical palliative care services at all SCHS sites and to play a major role in the development of further collaborative services with Eastern Health and Eastern Palliative Care. Initially, the position will be principally based at the Sisters of Charity Health Service, but a clinical leadership role in both Eastern Health and the Eastern Palliative Care will be developed and expanded over the next 2 years. It is envisaged that this position will then provide clinical leadership for all palliative care services in the Eastern and Central Eastern Regions of Melbourne, serving a population in excess of one million people.

The successful applicant will have an FRACP or equivalent with strong clinical experience in palliative medicine. Experience in service development and a track record in clinical research would be highly advantageous. Appropriate academic appointments, commensurate with academic record, will be arranged through the University of Melbourne and Monash University.

An attractive remuneration package will be negotiated, including a potential right of private practice and training and development benefits.

This position is a unique opportunity to establish a high profile clinical leadership role and to help grow and remodel a service with a long tradition and commitment to palliative medicine.

Closing date: Friday 30 August, 2002. Ref no: 1894.

Further enquiries regarding this position and academic activities can be directed to:

**SISTERS OF CHARITY  
HEALTH SERVICE:**

Professor Brendan Murphy,  
Director Medicine & Emergency Services,  
Phone +613 9288 3112  
Fax +613 9288 3151  
Email [murphybf@svhm.org.au](mailto:murphybf@svhm.org.au)

**CENTRE FOR PALLIATIVE CARE:**

Professor David Kissane  
Phone + 613 9416 0000  
Email [d.kissane@medicine.unimelb.edu.au](mailto:d.kissane@medicine.unimelb.edu.au)

**EASTERN HEALTH:**

Dr Joe McKendrick  
Phone +613 9895 3585  
Email [joe.mckendrick@boxhill.org.au](mailto:joe.mckendrick@boxhill.org.au)

**EASTERN PALLIATIVE CARE:**

Ms Lyn Hayes  
Phone +613 9294 4800  
Email [lhayes@epc.asn.au](mailto:lhayes@epc.asn.au)

HMAGPV 92753

Applications quoting the reference number should include a Curriculum Vitae and the names of 3 referees, and be addressed to:  
The Recruitment Officer, Human Resources, St Vincent's Hospital, PO Box 2900, Fitzroy, Victoria 3065.

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## The Practice of Palliative Medicine and Palliative Care - What is it that we do, and what is it that our patients can and should expect.

Palliative Medicine is that discipline of medical practice specifically addressing the needs of patients who have illnesses that are causing their health to deteriorate progressively, and often rapidly, towards death. It is the medical component of Palliative Care, a multidisciplinary area of health care. The aim of Palliative Care is the relief of symptoms, the maintenance of the best possible quality of life for the patient, within the limitations of their illness, and support for the family before and after the death of the patient. Patients and their families are usually introduced to palliative care when it becomes apparent that attempts at cure are no longer possible or appropriate. However, from the time of diagnosis of a potentially life threatening illness, or even from the time of suspicion of such an illness, patients and their families may face emotional and existential issues commonly addressed as part of Palliative Care.

Palliative Medicine is practiced within the context of a multidisciplinary Palliative Care team who bring a wide range of skills to patients in all venues of care (home, nursing home and hospital). No one doctor can acquire the skills to manage all problems faced in palliative care. We can only fulfil our role as practitioners of Palliative Medicine by working together with our colleagues on the multifaceted problems experienced by our patients and their families.

The application of the principles of Palliative Care should be a component of the practice of all medical practitioners. All doctors are exposed to the practice of Palliative Medicine during their training, and it remains a significant part of the day-to-day responsibility of general practitioners, oncologists, and many other doctors. Worldwide there are a growing number of physicians who specialise in the practice of Palliative Medicine. Formal training in the specialty of Palliative Medicine is now available through the Royal Australasian College of Physicians (RACP) or the Australasian Chapter of Palliative Medicine of the RACP. Although recognised in the UK and in New Zealand, Palliative Medicine is not yet formally recognised as a specialty by government in Australia.

All specialist practitioners, be they Palliative Medicine physicians, nurses, airline pilots or electricians, set boundaries that define their field of practice. At the same time almost all fields of human endeavour accept that there are grey areas of uncertainty, and palliative medicine is no exception.

The following goals and principles in the care of people dealing with life ending illness and death define the boundaries of the practice of Palliative Medicine as part of Palliative Care:

- Control of physical symptoms (e.g. pain, nausea, constipation, breathlessness)
- Management of mood disorders (depression, anxiety) and cognitive failure (confusion, delirium, dementia).
- Support in dealing with the practical difficulties caused by declining physical function and independence.
- Support for patients to explore the spiritual issues that are important to them.
- Support for the patient and their family in dealing with the issues of death, loss, grief, bereavement and existential distress generated by a life ending illness.
- Support for rights of the patient to make decisions about their own life from the choices that are available. These include the right to refuse or withdraw from life-prolonging or life-sustaining treatments.
- Ongoing provision of palliative care to the patient until the time of death, and for the family through bereavement, regardless of choices that they may have made
- It is not the aim of Palliative Medicine to either prolong life or hasten death, although either outcome may be an unexpected, or less commonly, a possible outcome of actions taken in pursuit of the points above. It may not be possible to know if either may have occurred given the uncertainty of the prediction of life expectancy. Such happenstance is part of all medical practice.

The Palliative Medicine community includes members with the full range of views on the complex end of life issues currently being addressed in our community. Most would agree with the following points:

- Most patients receiving palliative care are enabled to die with dignity and are acceptably comfortable for the majority of the time that they are unwell.

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- Many patients use the time while they are receiving palliative care to explore a variety of issues in their own philosophical, existential and/or religious life, and in their relationships with amenable to relief. This can be very satisfying and rewarding both for the patient and their family, and help lead towards a peaceful death for the patient and peace for their family.
- Palliative Medicine, while very effective in the relief of distress, does not claim to be able to control all pain or other symptoms.
- Even when physical symptoms are relieved, some patients continue to suffer significant distress due to existential, spiritual, emotional and psychological issues that may not be amenable to relief.
- The decision by a patient to refuse, or withdraw from, a possibly life sustaining or life prolonging treatment does not constitute euthanasia or suicide.
- Some patients, even though they may be experiencing no particular physical or emotional distress, wish to control the timing of their death.
- Doctors are not absolved of the responsibility to offer and provide ongoing palliative medicine regardless of the choices that patients may make. Nor can palliative care services refuse access to their support because such decisions have been made. At the same time, practitioners of Palliative Medicine cannot be expected to venture outside the boundaries of the practice of Palliative Medicine, or to act outside the dictates of their own conscience.
- All patients must be given access to appropriate symptom-relieving drugs. The risk that administration of such medication, carefully and expertly administered, will accelerate death is unlikely to be as great as previously believed, or as commonly stated. Any such risks, or the risk that the drugs will be used for purposes for which they were not intended, must be carefully weighed against the distress for the patient and their family if effective drugs are withheld. Risks are part and parcel of all areas of medical practice and all decisions carry risks, including decisions not to intervene.

- Unintended and unexpected outcomes are unavoidable when dealing with illnesses that often have highly variable and unpredictable courses. The discussion of these issues with patients is one of the responsibilities of medical practice.
- Doctors have a duty to act in the interests of their patients, but within the law, within their own ethical and moral framework, and within the commonly held values of their community. These imperatives can sometimes be in conflict.
- No patient should have their choices driven by a lack of access to high quality Palliative Medicine as part of Palliative Care services.

Most of the practice of Palliative Medicine in the delivery of Palliative Care is fairly straightforward. However at times there can be conflict between these principles and the wishes of individual patients, their families or other significant people in their lives. There can also be differences of opinion between Palliative Care team members. The disagreements that arise must be aired in the knowledge that resolution and consensus will not always be possible.

Practitioners of Palliative Medicine do not have the option to walk away from their duty to offer Palliative Care or refuse to bring their skills and experience to bear on the problems faced by dying people and their families. Actions outside the parameters described above, such as euthanasia, are not part of Palliative Medicine or Palliative Care. It is crucial that patients, their families and the community feel secure in the knowledge of what they can and cannot expect from practitioners of Palliative Medicine.

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