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Editor's Note

IT IS EXTRAORDINARY on reflection to note how much has occurred globally over the last few months since the Christmas Newsletter. Disasters which are beyond human control have at least taught us two lessons; first of all the frailty and limitations of human knowledge And secondly as we witnessed, the positive effect of the power of innocent suffering which unites humanity irrespective of all human barriers. How so true it is also for the many gestures we see with loss and grief in our own work.

ANZSPM

PO Box 7001, Watson ACT 2602
T 0458 203 229 | F 03 8677 7619

President: Dr Phillip Good
Newsletter Editor: Natasha Michael
Executive Officer: Marita Linkson
All e-mail: executive@anzspm.org.au
Website: www.anzspm.org.au

National Palliative Care Week, which runs from 23 to 28 May with the theme, *Let's have a chat about dying*, challenges us all to promote the important social dialogue and discourse on this issue within our organisations and communities. Palliative Care Australia lends us a helping hand with resources through www.palliativecare.org.au and we are reminded of our responsibilities by Margaret Meade who states that, "When a person is born we rejoice, and when they're married we jubilate, but when they die we try to pretend nothing has happened!"

We have tried in this edition to bring you a myriad of articles, some updates and a 'new look'. A simple taste of the wonderful diversity of the work we undertake in education, governance, clinical care and whole person care throughout Australia and New Zealand. I hope you enjoy a flick through; and many thanks to our willing contributors.

Natasha Michael
Editor

President's Report



By Phillip Good
President

IT HAS BEEN an amazing start to the year, with natural disasters in both Australia and New Zealand. Our thoughts are with our New Zealand

colleagues and especially those in Christchurch, where the city has been devastated by the recent earthquake. In my own experience of floods in Brisbane, I was really impressed by the community response and the ability of people to give generously in time, spirit, and financial support.

Recently, there was a call for expressions of interest for new members on the Palliative Medicine Education Committee. This has led to a number of new members, and I thank them for putting their names forward.

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President's Report

I really encourage you to be members of several different organisations, such as ANZSPM, P MEC, and the Chapter of Palliative Medicine. Being involved enables you to contribute to the development of our specialty, as well as to interact with colleagues from around Australia and New Zealand. Everyone is busy, but the more people who are willing to contribute, the less work there is for everyone.

This is a big year for education for ANZSPM. Once again we have our educational forums at ten cities throughout Australia and New Zealand, and I encourage you to attend.

A first for this year is the Medical and Surgical Update for Palliative Medicine. This is being held in Melbourne on 29–30 July 2011, and we have a fantastic line-up of speakers to talk about topics that are relevant to all those who work or have an interest in Palliative Medicine. See our website for details of all of our upcoming events: www.anzspm.org.au.

New Zealand Report



By Cathy Miller
Branch Chair

IT WOULD BE wrong to begin this newsletter without first mentioning thoughts for those who have endured the challenges of living with the

Christchurch earthquake and its consequences. The NZ Branch executive committee have had communications with some of the ANZSPM members in Christchurch and our thoughts have been with them during these difficult sad times. New Zealand as a community has risen to support the repair efforts in a number of ways, but there are some losses that can never be repaired and

will be felt forever. The loss is to the people of Christchurch, but also to the people of New Zealand and further afield.

May your spirits be strong at these times.

The four months since the last newsletter in December 2010 seem to have flown by. This week has been busy with the visit of **Frank Brennan**, who is presenting three forums around New Zealand, including one in Christchurch. Although Frank did not present at a forum in Auckland, several of us were privileged to have him share some of his writings, and I would encourage those of you who have a chance to listen to these at some future date to take up the opportunity.

Other news is that **Rod MacLeod**, one of our members, was appointed to the New Zealand Palliative Care Advisory Group. Rod tells me he has attended one meeting so far and came away with the view that the group has an impressive work plan and has made progress on a number of fronts. Rod will ensure that ANZSPM is given regular updates on the group's activities in the future. Rod is also a member of the Palliative Care Medication Working Group and will keep us informed about those activities.

There are a number of other important pieces of work that are being progressed within New Zealand, including the service specifications (which I understand may take another year or possibly longer to complete), work on guidance for advance care planning, the palliative care needs assessment and workforce planning – so lots to watch out for! Many of these activities will be reported on at the ANZSPM business meeting in Wellington, which will have passed by the time this newsletter is printed. New Zealand members will receive electronic reports on many of these topics.

NZ members are reminded that ANZSPM welcomes contributions to the newsletters and you are encouraged to forward interesting material to Marita for incorporation in future newsletters.

The NZ Branch executive committee welcome feedback as to how best to manage the branch on behalf of its members – please e-mail any of the executive members at any time.

Palliative Care Australia

By Scott Blackwell
President

AUSTRALIA MAY HAVE rated second in a study of hospice and palliative care services in 2010 but that leaves us with no room for complacency in 2011. The palliative care sector in Australia must now work as one to achieve better access for all Australians to such quality services.

The palliative care sector came into 2011 with a new national strategy endorsed in November 2010 by all the health ministers in Australia. Its goals in the areas of 'Awareness and Understanding', 'Appropriateness and Effectiveness', Leadership and Governance' and 'Capacity and Capability' give us a broad background on which to work.

Government strategy and policy is only ever thus: a broad brushed canvas with little detail. It is up to us to paint in the detail. In particular, palliative care needs its clinicians to step out of their busy lives and contribute to the detail. It is only by this approach that we will build access to our excellent services for those Australians who currently miss out.

Improving awareness and understanding is critical and at PCA we are emphasising the positives: maximising the life experience, minimising suffering and facilitating quality bereavement. Palliative care clinicians can and should promote this positive image for no other reason than that is what we do.

Enhancing capacity and capability is the way palliative care clinicians will attract more and better referrals to their quality services. Improving knowledge and understanding across all sectors of health is the time proven way of achieving this. Specialties that have followed this plan are indeed the best developed. In particular it is time now to turn your attention to the capacity and capability in primary care.

So where do we put the voluntary euthanasia (VE) debate in 2011? We are responsible for the good deaths of 100% of Australians who die this year. In countries where VE is legal, less than 0.5% die because of it. Let's get on with the good work that we do.

National Standards Assessment Program

NATIONAL STANDARDS ASSESSMENT Program (NSAP) is a quality improvement program available for all specialist palliative care services across Australia. It is a resource that enables services to engage in continuous quality improvement through self-assessment against the national palliative care standards, action plan development and implementation, as well as peer mentorship. Following a successful pilot program, NSAP was formally launched in July 2009 and now has 138 services participating in the program. NSAP has been funded by the Australian Government's Department of Health and Ageing through the National Palliative Care Program.

Continuous Quality Improvement (CQI)

CQI is not a one-off activity; relying on a cycle of improvement based around the 'Plan, Do, Study, Act' approach to change. Services undertaking NSAP complete a self-assessment every two years. Ninety-six services have completed a Cycle 1 self-assessment (including pilot services) with several more services underway. This provides an opportunity to regularly assess achievements against the national standards, understand performance at the point of assessment and to determine improvement since the previous assessment.

The focus on action plan development and implementation follows each self-assessment and NSAP supports this through Peer Mentorship and the NSAP Collaboratives Project.

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National Standards Assessment Program

Cycle 2 Workshop

Rushcutter's Bay, Sydney provided a beautiful backdrop for the NSAP Cycle 2 Workshop conducted during the first week of February 2011. It was impressive to see representation from 26 services coming together from across Australia. These services formed the original NSAP pilot cohort, completing their individual service self-assessments over the three months prior to January 2009.

Day 1 of the workshop focused participants on the theme 'Improving Palliative Care – How to make improvements happen'. The facilitator, **Dr Jan Davies**, moved the attendees through objectives that included techniques for improving care, developing a quality improvement action plan and understanding the factors that make changes sustainable. The feedback from this first day was positive. Most agreed that change is best achieved in small chunks and requires sound structure and an increase in education for all staff around continuous quality improvement.



The second day moved Cycle 2 attendees through the progressive changes that have occurred within NSAP. The practical session was very popular, with colleagues given the opportunity to go through a national standard for self-assessment in small groups as though holding a mock MDT meeting. One important part of the day was taking participants through the online reporting process; this highlighted some significant changes since this cohort's Cycle 1 experience.

Major new work underway

1. Cycle 2 self-assessments
2. Distribution of the NSAP National Quality Report
3. NSAP Collaboratives Project – Assessment and Care planning
4. NSAP Peer Mentor program
5. NSAP for Residential Aged Care – investigating a model for use of NSAP in this environment

NSAP has also signed a Memorandum of Understanding with PCOC and CareSearch to ensure opportunities for collaboration are realised.

Caresearch / NSAP / PCOC: Evidence / Standards / Outcomes

An aligned approach to supporting change management in palliative care.

For queries about NSAP please contact the NSAP team: Claudia, Janie, Helen, Phil and Krysia by e-mail: nsap@palliativecare.org.au or phone: **02 6163 8419**.

1. Palliative Care Australia (2005) Standards for Providing Quality Palliative Care for all Australians, PCA, Canberra.

From 'DNR' to 'AND' – Changing EOL Care Communication

By Kirsty Campbell
Pain and Palliative Care services
The Children's Hospital at Westmead

MAKING END OF life (EOL) care choices for children is an extremely difficult task for parents and clinicians. Discussions about EOL care options are often framed in terms of a negative approach of what not to do, and the withdrawal of care. Experiences for families are more difficult if discussions are poorly documented, information not shared with appropriate clinicians or if parents are asked to repeat difficult conversations. All of these are exacerbated by a system of barriers and inconsistent practice.

In order to address these issues, a project was developed with the aim of improving the language used in EOL care planning, strengthening and streamlining the process for documenting decisions, and developing the role of paramedics in EOL care for children at home.

Improving the language used in EOL care planning

The language used in EOL care discussions can be negative and the term 'Do Not Resuscitate' (DNR) may imply withdrawal of care. We introduced the phrase 'Allow a Natural Death' (*AND*) into EOL decision-making discussion as a positive approach to determining the support needed for the natural dying process. This terminology is already in use in some services in New Zealand, and Jones *et al.* showed overall agreement by study participants that this language was more family-centred. A policy to reflect these changes was developed and introduced to the hospital setting.

Strengthening documentation

A new form to document the EOL care discussions was developed. This provided consistent structure to the conversations being held, as well as constructive guidance to clinicians about the types of language and care options to discuss. It identified a consistent location for the information in the patients' medical record.



Pictured above, from left: Jude Frost, Tina McLean, John Collins, Meagan Delaney, Julie Greathouse, Amanda Fernando, Mary Cossich, Lyn Lane, Wendy Edmonds, Renee Ingram.

The role of paramedics

Until now, ambulance protocols have required paramedics to commence CPR and transport the child to the nearest hospital, even if these are not the wishes of the family. The project utilised an electronic flagging system to alert the call centre operator and paramedics to the existence of EOL care plans.

Evaluation confirmed 100% satisfaction. Twenty per cent of staff included IV antibiotics as an additional care choice and this was added to the form.

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The joys and challenges of palliative care in West Moreton

By Judith McEniery
Staff Specialist in Palliative
Medicine, Ipswich

IPSWICH, BIG ENOUGH to matter, small enough to care! Half a century ago, this was a relatively unknown provincial city, boasting coal mining and woollen mills as its major industries. My family moved here just as I started school, and my father practiced here as solo general practitioner for almost thirty years. Having spent my childhood and adolescence here, Ipswich will always be “home” to me. Following graduation, I lived and worked in Brisbane, New South Wales and London, prior to settling back in Ipswich in the late 1980s as part-time general practitioner. Spending my formative years here, and my time in General Practice, has each strongly influenced my day-to-day functioning as Palliative Care Doctor in Ipswich.

When, in the late 1990s, I serendipitously ventured into a palliative care position at Ipswich Hospital, Ipswich was changing. Gone were the mills, and closed were the large underground mines. The region was becoming known for educational facilities, great lifestyle, and recreational activities. To the east is Brisbane, and to the west are the rural and agricultural areas of the Brisbane, Lockyer and Fassifern Valleys. Ipswich is 40 minutes’ drive from Brisbane and 60 minutes from the Gold Coast.

With sub-tropical climate, Ipswich is now recognised as a safe, friendly and multicultural city, with residents coming from 115 ethnic backgrounds, and 84 languages spoken.

Due to the long-term stability of a significant portion of the population, many folk have known either me, or members of my family, over several decades. Hence, not infrequently during my role in the Palliative Care service, I encounter patients who recognise me through one or another connection. To be greeted upon consultation

as “Ted’s sister”, “Natasha’s aunt” or many a time as “Doctor Mc’s daughter” is surely an aid to familiarity.

I am sure this recognition has enabled an acceptance and trust which may not otherwise have been achieved within their life span. I have cared for many of the parents and now siblings of those from my school class – what an advantage in escalating development of a therapeutic relationship! Just think – features of our therapeutic relationships being productive include unconditional acceptance, empathy, concreteness and professionalism. It has certainly facilitated this process to share background to such a degree. How different from the formal and often impersonal interaction when one works in a ‘foreign’ community and needs to develop these interactions. Sometimes as professionals it is tempting to hide behind a kind of anonymity that fits easily with aspects of modern, especially high-tech, medicine.

Seamless care and continuity
assume new meaning when a
palliative care service has cared
for three siblings over time.

Seamless care and continuity assume new meaning when a palliative care service has cared for three siblings over time; a mother and then, nine years on, her daughter with the same diagnosis; and a mother-son, father-son and husband-wife combination (the latter as in-patients at the same time!). To have supported in their terminal illness, community members such as a school principal, pharmacist, members of the clergy, a member of Parliament, sports celebrities, medical colleagues and numerous loved ones of same, has been indeed a privilege over the past decade.

Like Ipswich itself, palliative care in our rapidly expanding local community is changing. Many people now live in Ipswich and work in Brisbane, and significant numbers of those who work in Ipswich city are living in surrounding rural areas. Suburbs are being established with relatively poor access to health facilities and services. Palliative care is also changing, with greater emphasis on involvement with non-malignant conditions and on early referral for symptom control issues for those having active therapies.

Much of the expanding activity of palliative care services can be provided in the community, including a presence in residential aged care facilities. There is great potential for 'hospital in the home' provision and admission avoidance. It seems we are on the threshold of an exciting new phase for the West Moreton Palliative Care service, if adequate response to these changes occurs.

Being involved in care of the terminally ill in my "home town" has been a pleasure and incredible privilege. Like so many of you, I have seen at close range the amazing courage and dignity, resourcefulness and resilience of carers and patients, as people I have known, or who have known me, have journeyed through their illnesses. Though the instances of such familiarity now become less frequent, the quality, carefulness and warmth of our service can continue, as modern therapeutics and evidence-based protocols pervade our care provision. So it is my hope that the Ipswich service can continue to provide care that is efficient and compassionate and at the same time be holistic and equitable in a modern setting. □

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From 'DNR' to 'AND' – Changing EOL Care Communication

There have been no complaints or incidents relating to the new *AND* form and policy since its introduction. Feedback from families has been extremely positive, in particular with regard to not having to explain their situation over and over again.

This project is being implemented in metropolitan Sydney for children under the care of the Palliative Care service at The Children's Hospital at Westmead.

The *AND* Policy, protocols and processes with the NSW Ambulance Service will be made available to other paediatric palliative care services in NSW and will be extended to regional NSW Ambulance Service areas.

★ **This project was awarded a NSW Health Award in 2010.**

1. Jones BL, Parker-Raley J, Higgerson R *et al.* Finding the right words: using the terms allow natural death (AND) and do not resuscitate (DNR) in paediatric palliative care. *Journal for Healthcare Quality.* 30 (5),55-63.

Reflections of a medical student



By Logan Shemer

I AM AN undergraduate final year medical student in my mid-twenties, at an Australian university. Having completed five years of medical school, with two-and-a-half years

in the clinical setting, I believed that I had some understanding of the medical profession. This was until my last unit at the end of 2010, when I was exposed to one week of palliative medicine. I'm rather ashamed to admit that my thoughts on palliative care were at that stage synonymous with the elderly and hospice care, however I was soon to learn otherwise.

Within a very short space of time it became apparent that contrary to my preconceived ideas, the specialty's purpose is actually to provide aid to those struck by life-limiting illnesses, to assist them in achieving the maximum quality of life and, when the time comes, to provide empathy and support during their final days. As my interest in this field had been piqued, I decided to investigate further and do an elective with the palliative care service at a metropolitan hospital.

I was warmly welcomed into the fold.

The first experience that showed me the brighter side to palliative care was when I recognised a patient walking past me whom I had first met during my initial rotation. Had she not been wearing a hospital gown, one would never have known she was terminal. She was in her late twenties and when I first met her two months prior, she was bed bound, incapacitated by intractable pain and diagnosed with metastatic breast cancer. This young woman, only slightly older than I, was going to die. Her condition was so severe that the treating team had advised her family to come from abroad to say their goodbyes.

I was thus surprised when I saw her walking around looking so well only two months later.

I inquired as to what had happened, and was told that her hypercalcaemia had been treated and she was currently on a Ketamine driver. It was at this point that she told me that the word palliative came from the Latin *pallium* – to cloak.

Another enlightening moment occurred during a ward round, when we went to see an elderly patient with a GCS of eight. After the registrar's summary of the myriad of chronic diseases the patient was suffering, my supervisor turned to me and said, "Now Logan, what is the diagnosis?" I tried to be a smart med student and arrive at a significant and correct answer, when something in my supervisor's eyes told me that I was over-thinking the question. I said what I felt in my gut. I leaned close to her and said, "I think he's dying."

We are here to treat humans,
not diseases, and when the time
comes for a patient to die while
in our care, there are still
things that can be done, things
that are not in textbooks.

By chance, I was right, which then led to a discussion of the clinical signs of dying. But her point was that, typically, medical students are not taught how to diagnose 'dying'. The significance of this, she explained, was to allow us to decide when to make that all-important call to the family or significant others. Do we warn them of the impending end of their loved one, or do we just leave their loved ones to die alone, in the middle of the night, and then sign their death certificate? We are here to treat humans, not diseases, and when the time comes for a patient to die while in our care, there are still things that can be done, things that are not in textbooks. I will never forget this wisdom and promised myself that when I am able I will impart it to other medical students.

The best way to understand what is done by the pain and palliative care team is to observe a multi-disciplinary meeting, where physicians, registrars, psychologists, psychiatrists, pharmacists, nurses, social workers, and pastoral care specialists come together to discuss a patient's welfare.

First, the 'death list' is addressed: a review of the patients under their care who have died during the previous week. While this may seem somewhat morbid to some, I found it very interesting as it showed another side of medicine. Some respectful reminiscing about the patient, their family or lack thereof, would take place and a decision as to who would send the appropriate letter of regret would be made; all irrelevant to medicine, but done nonetheless. This would then be followed by the usual business regarding in-patients and new admissions, and a discussion of possible treatments and related issues.

It was a most humbling experience to see the difference that this handful or so of dedicated professionals could make to the lives of patients entrusted to their care.

So, what has this experience taught me? I have learned that palliative care as a profession is better suited to a seasoned physician. As much as I would love to engage in such an admirable practice, I lack the life experience. This was made evident to me when I was briefly left alone in outpatients with a patient who had been told that though she had battled metastatic cancer for more than a decade, she needed to prepare for the inevitable end.

After the consultant had left the room, the silence was deafening, and I naively asked, "What would

you like to do before the end?" I was astounded when she answered, "I think I should tell my kids what's going on, but most of all I want my husband to be all right after I die." The selflessness and simplicity of her answer touched me in a way that I find difficult to express in words.

To put her answer in perspective, her husband is in his late fifties, fit and healthy, and her only concern was that he would remain well without her. Once the consultation had concluded, my supervisor and I left the room. I discreetly looked through the blinds, and as she had predicted, the husband had moved his chair from the corner of the room to sit next to his wife and they wept.

It was at that moment I realised, I could not do this job. I lacked the experience – both practical and emotional – that is required when dealing with such patients. These are the qualities and skills that truly set the members of the department and multi-disciplinary team apart from others in the medical field.

To conclude, I am most interested in, yet somewhat concerned about, the future of palliative care in Australia. With continual advances in medicine and further classifications of chronic and life-limiting illnesses, more patients will fall under the palliative care umbrella.

The question I ask is: how will we facilitate the care of these patients with the current under-resourcing in medicine? It saddens me to think that many may fall through the gaps and miss out on an invaluable service of which I have had the privilege to see first-hand. □

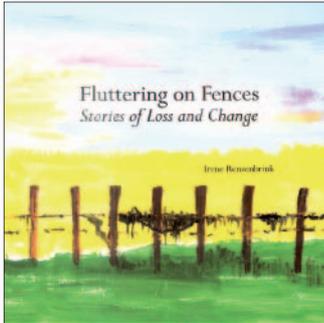


Australia Day honours

ANZSPM would like to congratulate the following Fellows on their awards and thank them for their extraordinary contributions to palliative care services.

- **Dr John Joseph Collins** AO FRACP FACHPM, Balmain, NSW
Service to paediatric palliative care
Member of the Order of Australia
- **Dr Rosalie Jean Shaw** PSM OAM, Ferguson, Vic
Asia Pacific Hospice Palliative Care Network
Medal of the Order of Australia
- **Professor Ian Norman Olver** FRACP FACChPM
The Cancer Council Australia
Member of the Order of Australia (AM)

Book review



Fluttering on Fences: Stories of Loss and Change

by Irene Rezenbrink

Lakeside Education and Training 2010
Price: CAN\$21.95
www.mcnallyrobinson.com

A SHREDDED PURPLE plastic bag, fluttering from a barbed-wire fence, reminded Irene Rezenbrink about Katherine Manfield's reflection that shreds of one's life are left in places where one has lived. This pivotal moment, experienced in Saskatchewan in 1997 when Rezenbrink grieved for life left in Australia, consoled and enlightened. Although a pioneer in Australian palliative care, bereavement counselling and education since the 1970s, Rezenbrink intensely realised that, when words fail, an image that "captures the essence and complexity of our experience" can comfort, heal, and transform.

This book is a collection of engaging stories and reflections about loss and change in Irene Rezenbrink's personal and professional life, interspersed with Rezenbrink's photos of fluttering images across vastly different landscapes, bereavement theory, and profound quotes by authors such as Colin Murray Parkes, Kubler Ross, and Goethe. The reader is taken on a journey through Rezenbrink's recollections of a grandmother with dementia, losses of friends through death, and losses involved with personal illness, an ageing parent and precious mementos. We also gain insight into losses experienced by others like Rob who, despite the deaths of three brothers and two offspring, believes he is living a fortunate life. He helped his family to remember the lost brothers by creating furniture from a silky oak that one brother had planted 35 years earlier (when it needed to be removed). These stories provide moving insights into grief, the challenges of resultant destabilisation, and opportunities for compassion, cohesion, and creatively experiencing growth. Rezenbrink states:

"The fluttering fragments in the photographs represent both the pain of loss and its healing transformation over time".

This book is testament to Irene Rezenbrink's belief that storytelling and the creative arts can help us deal with and make sense of life crises and turmoil through promoting greater self-knowledge, compassion, and healing. Reading the text and musing over the photos and quotes was an educative and nurturing experience because I was drawn to reconsider some of my own work life and personal loss encounters. As a palliative care music therapist, I believe that music can comfort and enlighten because it has multiple meanings and we may project onto it what we need. Meanings ascribed to music may also change over time. Clearly visual art, including the fluttering of plastic bags, has the same power. I recommend that anyone affected by loss and grief read and reflect on this book.

Clare O'Callaghan
Caritas Christi Hospice
St Vincent's Hospital and
Peter MacCallum Cancer Centre



Queensland Government

Calling for expressions of interest:

Palliative Medicine Consultant

Palliative Medicine Consultant, with FACHPM or equivalent, wanted for full-time position at Ipswich Hospital, covering in-patient and consultative component of the Ipswich and West Moreton Palliative Care Service.

This stimulating position in a well-established team would work in conjunction with a Community Consultant, sharing on-call commitments. Further details soon, position to be appointed from July 2011, but enquiries and visits welcome.

To discuss, please e-mail Dr Judith McEniery: judith_mcenery@health.qld.gov.au

The Australian & New Zealand Society of Palliative Medicine presents its inaugural
**MEDICAL & SURGICAL UPDATE
FOR PALLIATIVE MEDICINE**

*For Palliative Medicine Specialists & Trainees, GPs & Specialists, and Nurse
Practitioners with an interest in Palliative Medicine*

INVITATION TO ATTEND

It gives me great pleasure to invite you to the inaugural ANZSPM Medical and Surgical Update for Palliative Medicine. This is a new and exciting interactive style meeting will provide state of the art updates for areas relevant to practitioners who work in, or have an interest in, Palliative Medicine. This initial meeting has a broad range of topics with high quality speakers, and promises to be a valuable learning experience for all attendees. I look forward to seeing you there.

Dr Phillip Good, President, ANZSPM



PROGRAM OUTLINE

FRIDAY 29 JULY
Arrival tea & coffee
Orthopaedics
Radiology
Radiation Oncology
Lunch
Renal
Afternoon Tea
Respiratory
Technology

SATURDAY 30 JULY
Breakfast
Addiction Medicine
Opioid Update
Chronic Pain
Morning tea
Oncology
Nutrition
Survivorship
Lunch
Neurology
Geriatrics
Delirium

SPONSORS



REGISTRATIONS NOW OPEN

We are delighted to announce that registrations are now open. You can download the registration brochure from the ANZSPM Website – we suggest you read through this document prior to registering.

You have two ways to register for the Conference. You can register online (www.anzspm.org.au) and click on the Conference link (preferred method) or you can complete the registration form attached to the registration brochure.

For more information visit www.anzspm.org.au or contact the ANZSPM Conference Secretariat:
PO Box 180, Morisset NSW 2264
Tel: +61 2 4973 6573 Fax: +61 2 4973 6609
Email: anzspm@willorganise.com.au



ANZSPM Updates

ANZSPM 2011 Palliative Care Forum Series

These Forums will be held on weekday evenings and will include a light meal, a formal presentation, and a panel-led case study discussion. Register on-line at www.anzspm.org.au

Communication with Patients and Family at the End of Life, featuring Dr Peter Kirk, will be held in Darwin, Perth and Adelaide:

- Monday, 6 June – Darwin
- Tuesday, 7 June – Perth
- Wednesday, 8 June – Adelaide

Gastrointestinal Symptoms, featuring A/Prof Katherine Clark, will be held in Brisbane, Melbourne, Hobart and Sydney:

- Wednesday, 15 June – Brisbane
- Monday, 27 June – Melbourne
- Tuesday, 28 June – Hobart
- Thursday, 7 July – Sydney

More information can be found on the ANZSPM website at: www.anzspm.org.au

BMJ Supportive & Palliative Care to become an Official Journal of ANZSPM

ANZSPM has agreed to enter into an agreement with BMJ Group which will see BMJ Supportive & Palliative Care become another official journal of ANZSPM. Members will avail of a 30% discount of the personal subscription rates. One or more representatives of ANZSPM will be nominated to sit on the Editorial Board of the journal and the BMJ Group will consider news and events submitted by ANZSPM for publication on the journal's online blog and print edition.

Further information will become available once the agreement is in place.

ANZSPM Website Update

The ANZSPM website now features an **Events Calendar** which has a chronological listing of all current and planned ANZSPM events. The addition of this feature has allowed us to have online registration facilities, which we have been using for our Palliative Care Forums. It also allows us to easily e-mail delegates who have registered for an event.

The Events Calendar is available via the ANZSPM EVENTS tab on our home page at: www.anzspm.org.au



Save the Date:

ANZSPM's 2012 Conference, 'Collaboration in Palliative Care', will be held from 4-7 September 2012 in Queenstown, New Zealand.

CENTRE for
PALLIATIVE
CARE

The VPMT is auspiced by the Centre for Palliative Care, which is part of St Vincent's Hospital and is a Collaborative Centre of The University of Melbourne.

In collaboration with the Centre for Palliative Care, the VPMT is a state-wide program funded by the Victorian Cancer Action Plan. The VPMT aims to build and sustain a high quality palliative medicine workforce in Victoria. This includes specialist palliative care physicians and doctors from other specialties.

Victorian Palliative Medicine Training Program

www.vpmt.org.au

Applications are invited from medical practitioners interested in:

- undertaking advanced training in palliative medicine with the Royal Australasian College of Physicians (RACP), or
- undertaking training towards chapter fellowship with the Royal Australasian College of Physicians (FACChPM), or
- gaining experience as part of training in another specialty such as oncology, geriatrics, general practice or paediatrics.

Appointments will be for 6 or 12 months. Some positions are suitable for doctors wishing to undertake the 6 month Clinical Diploma of Palliative Medicine. Several Fellows positions will also be available in 2012.

Applications close Wednesday 10 August 2011

Check the website for further details including information on participating accredited Palliative Care Units and the application process.

VPMT

VICTORIAN PALLIATIVE MEDICINE
TRAINING PROGRAM

