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President's report



By Frank Brennan

THE WORLD OF palliative care generally and that of palliative medicine specifically

was delighted with the recent announcement that **Professor Ian Maddocks** had been chosen as the Senior Australian of the Year. This is a great tribute to Ian and his pioneering and sustained work in our discipline. Ian was the inaugural President of ANZSPM and it is most fitting that this announcement comes around the time of the 20th anniversary of the formation of ANZSPM.

ANZSPM is one of a multitude of societies representing medical specialists in Australia and New Zealand. How these societies collectively and individually relate to the College of Physicians has been the topic of numerous discussions over recent years. After significant background work, all of the societies have signed a collective Memorandum of Understanding (MOU). The next part of this process involves each society entering into separate MOUs with the College. We are delighted that this MOU has now been finalised between ANZSPM and the College of Physicians.

The first iteration of the ANZSPM Fora of 2012-2013 is complete. The theme was 'Palliative Care in an Aged Care setting'. We are most grateful to the speakers and convenors at all of the sites. The speakers in Australia were **Professor Liz Reymond** (palliative medicine) and **Professor Jan Potter** (geriatrics). The speakers in New

Zealand were **Amanda Landers** (palliative medicine) and **Maree Todd** (geriatrics). The feedbacks from each of the venues have been uniformly excellent.

The idea of two disciplines presenting one topic was novel for the Fora, but also obvious and vital, especially given the importance of aged care and the role of the two disciplines. We are currently preparing for the 2013 ANZSPM Fora that will take place in Geelong, Gold Coast, Sydney, Adelaide and Perth. Details will follow.

In addition to the Fora, there are several other educational events being organised. The next ANZSPM Trainee Day shall be held in Sydney on 3 May. An excellent program has been created by **Vicki Tai**, the ANZSPM Trainee representative. All trainees are encouraged to attend. In addition, a committee chaired by **Mark Boughey** is progressing well with the organisation of the ANZSPM Medical and Surgical Update for Palliative Medicine 2013. The 2011 event was a great success and all ANZSPM members should consider attending the upcoming meeting on 28-29 June. In New Zealand, the Aotearoa Education Day and Annual Business Meeting will be held in Wellington on 20-21 July.

ANZSPM Council has endorsed the Brisbane South Palliative Care Collaborative Palliative Care Toolkit project. The chairperson for this project is **Liz Reymond**, Professor of Palliative Care. **Michael Chapman** is the ANZSPM representative on the project.

ANZSPM Council is delighted to welcome **Murray Hunt** as the new representative from New Zealand. Murray brings great experience in palliative medicine and local

ANZSPM

Editor's note



IT IS WITH great pleasure and enthusiasm that I start my tenure as editor of this newsletter.

A big thank you to the outgoing editor **Natasha Michael** for all of her hard work over the last two years and for her guidance during our transition over the last few months. I promise to try my hardest and uphold the high standards you have set for this publication!

I would like to encourage each and every member of ANZSPM to contribute to the newsletter by sharing his or her thoughts and stories, hopes and fears, inspirations and disappointments. In particular, I am very keen for trainees to become involved by reflecting on their clinical experiences, recounting their impressions of conferences and meetings and participating in our journal club. If you come across something or someone that you think would interest the rest of the palliative medicine community, please drop us a line!

Ours is a young and growing specialty and it's a wonderful time to become a part of it. Together we can turn this newsletter into both a mirror and a sounding board, reflecting and promoting what is happening in palliative medicine across Australia and New Zealand!

President's report

◀ Continued from page 1

leadership to the Waikato region of New Zealand.

After the excellent work of **Natasha Michael** as editor of this newsletter, we are delighted to welcome **Chi Li** as the new editor. The newsletter is a very important way of communicating to all of our members across Australia and New Zealand. We wish Chi all the best in his new role.

ANZSPM Aotearoa Branch Chair's report



By Sinead Donnelly

AS SUMMER DRAWS to a close, it is time to once again provide an update on ANZSPM Aotearoa activities over the past three months.

Murray Hunt joined ANZSPM Council as a New Zealand representative with me. **Cathy Miller** has stepped down from her position as Deputy Chair and Murray has kindly agreed to fill that position for the coming year.

Along with the rest of the Branch Executive, **Sara Rishworth**, **Ian Smiley** and I have been preparing for the Annual Education Day and Business Meeting on 20–21 July in Wellington. The registration weblink will be circulated to ANZSPM Aotearoa members in the near future. The program will follow within four to six weeks. Due to the lack of sponsorship this year, the Annual Meeting registration fee has increased. Despite this, the cost of the meeting may still not be covered entirely,

but further discussions on how to have a financially sustainable annual meeting will take place at the July gathering. The executive has agreed to accommodate ANZSPM members who need financial assistance in paying the registration fee.

The executive offers its condolences to ANZSPM Council member **Rohan Vora** on the death of his wife, **Barbara**.

Carol McAllum, who has represented ANZSPM on the Palliative Care Council in New Zealand superbly over the last few years, is stepping down from this position. During her tenure, Carol has made this a very effective and important role. Expressions of interest for the position will be circulated to ANZSPM Aotearoa members.

The New Zealand Parliament is again in session and there is a possibility that **Maryan Street's** Private Member's bill in favour of the legalisation of euthanasia may be drawn. Maryan Street is no longer Labour's spokesperson on Health. ANZSPM executive members have informally met local MPs to explain our views on this bill. ANZSPM Aotearoa has also published an article outlining our views regarding this matter in *New Zealand Doctor* in December 2012. ANZSPM Aotearoa welcomes the draft position statement circulated by the College of Physicians Wellington, which parallels New Zealand Medical Association's position in opposing the legalisation of euthanasia. We eagerly await the final formal statement. ANZSPM Aotearoa Executive members have contributed to the current Council review of the ANZSPM Position Statement on Euthanasia and Assisted Suicide.

Just before Christmas, the Association of Salaried Medical Specialists published an article by ANZSPM Aotearoa in their newsletter, which explored the importance of creating a sustainable palliative medicine workforce. We will explore this topic further as a debate at our forthcoming July meeting.

Nga mihi mahana
Gach Dea Gui
Every best wish

Murray Hunt

New ANZSPM Aotearoa Branch Deputy Chair

MURRAY STARTED PRACTISING palliative medicine in Taranaki, New Zealand in the early 1990s. He was inspired by a small but dedicated nursing team who also became his early mentors and teachers. He was awarded a Donny Hospice Fellowship in 1995 and completed a Diploma in Palliative Medicine (University of Cardiff) that year. As Medical Director of South Auckland Hospice, Murray promoted relationships between hospice and hospital and was instrumental in establishing regular interdisciplinary study days in palliative care.

After achieving his FChPM, Murray diversified and gained considerable experience in addiction medicine,



becoming the medical director of the largest alcohol and drug treatment service in New Zealand. This addiction work allowed him time to recharge his batteries (there were no on-call responsibilities), provided increased opportunities for

family life, and also offered fresh insights into both human nature and opiate medications.

Murray has also previously held Senior Clinical Lecturer positions with two New Zealand universities.

Murray is currently Clinical Director of Palliative Medicine with the Waikato DHB in Hamilton and Medical Director of Waipuna Hospice at Tauranga. He feels privileged holding both hospital and community palliative medicine roles and is keen to further training opportunities regardless of discipline. He tries to stay up-to-date in addiction medicine, although clinically this translates to conducting occasional assessments of impaired health professionals.

Murray lives in Tauranga with family, still drives Landrovers, and is a keen fisherman.

ANZSPM publication timetable*

ANZSPM Newsletter – published March, July & November; E-Update – published every other month except August and December. * Timetable is indicative and subject to change at ANZSPM's discretion.

Publication	Material deadline	Earliest closing deadline for Position Vacant ads	Publishing timeframe
E-Update January	24 January	7 February	End of January
E-Update February	21 February	7 March	End of February
ANZSPM Newsletter March	15 February	10 April	Mid-late March
E-Update April	23 April	7 May	End of April
E-Update May	24 May	7 June	End of May
E-Update June	23 June	7 July	End of June
ANZSPM Newsletter July	15 June	10 August	Mid-late July
E-Update September	23 September	7 October	End of September
E-Update October	23 October	7 November	End of October
ANZSPM Newsletter November	15 October	10 December	Mid-late November

NEWS

‘Reaching Out: Community, Communicating, Connecting’

Palliative Care NSW State Conference Dubbo 2012

By Joan Ryan
Education Committee Chair,
Palliative Care NSW

THE DEGREE OF energy and planning that goes into planning for a conference such as the 2012 NSW State Palliative Care Conference is enormous, but the rewards are well worth the effort. So it is always a relief when the conference gets off to a good start, as evidenced by the buzz of excitement during the welcome drinks at the Western Plains Cultural Centre.

The Mayor of Dubbo, **Matthew Dickerson**, welcomed friends and colleagues and the relaxed evening set the tone of the conference as one of energy, friendliness and networking with new and old acquaintances. Our private viewing of the Archibald Prize finalists in the Art Gallery proved a fantastic bonus to welcome all into the city of Dubbo.



Above: The historic Dubbo courthouse.

The feedback from our delegates has been overwhelmingly positive. We were so fortunate to have the support of such varied and interesting speakers, who gave their time and knowledge generously. We broke the conference record for poster presentations, with 16 posters on display. Congratulations to **Charmaine**

O’Connor from Liverpool Hospital for taking out first prize in the poster competition.

The abstract submissions were also of excellent quality, culminating in three concurrent sessions with 32 oral presentations. The inclusion of four concurrent workshops provided an eclectic range of topics, including literature and storytelling, websites, the NSW Ambulance Services and the art of Mindfulness. We had two panel discussions – one on aged care and the other on renal palliative care – exploring the changing landscape of palliative care in both patient populations.

The social events included early morning guided tours of Western Plains Zoo with our experienced guide, **Jenny Furney**. For a more relaxed start to the day, there was yoga and meditation on the banks of the Macquarie River with **Cath Brennan**. The GP breakfast at Dubbo Zoo was packed to capacity. **Professor Katy Clarke** delivered a very comprehensive and controversial update on pain management, which was well received by those present. The Conference Dinner at the Dubbo Gaol did not disappoint and provided a fantastic venue, fine food and wine. All had music to delight with plenty of chatter along the way.

The NSW Minister for Health, **The Hon. Jillian Skinner**, gave a special address to officially open the conference, outlining the Government’s intention to commit



Left: NSW Minister for Health, The Honourable Jillian Skinner, addresses the conference.

Photo courtesy of Linda Hansen

additional funding to palliative care over the next four years. The welcome to country by **Diane McNabo** provided a very special experience and sent a hush through the auditorium that was almost palpable. The rawness and beauty of the moment almost took my breath away and perfectly complemented our conference theme of 'community, communicating and connecting'. To then turn to the magic and poetry of a proud Wiradjuri man such as **River Bank Frank** was another great surprise. His use of humour was spellbinding and powerful. It is easy to see why Frank is a respected communicator, reconciliation advocate and could in fact be a great adviser to the Minister of Health as he himself suggested!

It was very fitting that a local delivered the Barbara Leroy Memorial Lecture, as Barbara pioneered palliative care in western New South Wales. **Lynne Sykes** is also recognised as the pioneer of a family-focused approach to succession planning in family farming businesses through facilitated family meetings. With such an agenda, Lynne's experience in communication skills and leadership qualities is apparent and equally relevant in the health care setting. She explored the issue of succession planning and stressed the importance of clear and open communication within the workforce. This presentation sparked much discussion throughout the conference with the possibility of influencing workforce concerns.

Professor Rod MacLeod talked about the fine balance between evidence-based best practice and the importance of wisdom, experience and intuition. Rod explored the realm of compassion that begs the question – can we teach it, how do we show compassion, and at what cost to ourselves as care givers? Once again, there was a focus on communication and self-awareness and the importance of what we bring as individuals to the patient-centred relationship and whole-person care.

We were very fortunate to welcome **Dr Sarah Wenham** to New South Wales and congratulate her on her new posting as Palliative Care Staff Specialist in Broken Hill and Far West. Sarah has recently arrived from the UK and gave a wonderful overview in 'Planning Ahead: from North West England to Far West NSW'. Sarah gave a detailed account of end-of-life care in the UK, referring to the Gold Standards Framework and the challenges of providing quality palliative care in patients with non-malignant disease. Sarah has been involved in End of Life Steering Groups in the UK and is a keen advocate for advance care planning, so will be a valuable addition to the Far West Region and indeed New South Wales as a whole.

We were fortunate to have the support of such varied and interesting speakers, who gave their time and knowledge generously.

Armed with his vast experience in palliative care, **A/Prof. Richard Chye** provided a valuable addition to the panel discussion on 'Muriel Dale: Aged and Frail'. Whilst many of us are familiar with a typical Muriel Dale presentation to an acute hospital setting, the solutions are not always clear and often complex. The panel stressed the need for careful and measured end-of-life decision making, collaborative assessment, and defining clear goals of care that are then skilfully communicated and supported by meticulous documentation. The navigation of the Muriel Dales through the health care system continues to be recognised as a major concern for future palliative care providers and so advance care planning is vital along with partnerships in the care of these aged and frail patients.

Dr Frank Brennan led a team of local care providers exploring renal palliative care in rural areas. He focused discussions on three patient scenarios highlighting geography, isolation, complex social and family needs and symptom management. It was apparent from discussions that providing dialysis in rural areas may compromise quality of life. It may even fracture families by forcing them to relocate closer to renal services. It was suggested that the decision to continue or withdraw from dialysis might be influenced by geography when family life may be disconnected. Once again, communication is a key factor in exploring these issues within communities and conversations around planning need to be timely and sensitive. Frank's book *Palliative Care – A Reader* is a wonderful resource and available online via the renal department at St George Hospital. This presentation was further supported by data from research currently underway in this department.

Dr Bob North is a retired surgeon who arrived in Dubbo in 1968 and has clocked up over thirty years of experience as a surgeon, followed by a role as Sub Dean of the Dubbo Campus of the University of Sydney, School of Rural Health. Bob has remarkable insight into the delivery of health care in rural New South Wales and his address, 'Words from the Wise', demonstrated his capacity to provide sound clinical judgement and make decisions under duress, with limited support but with an abundance of compassion. Bob has really been a true palliative care pioneer in his approach to and recognition of the key elements facing quality of life and end-of-life decisions as a surgeon committed to the relief of human suffering and distress.

In his closing address as the President of Palliative Care NSW, **Peter Cleasby** highlighted many of the challenges ahead for palliative care and encouraged us not to lose

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NEWS

Palliative Care NSW State Conference Dubbo 2012

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heart as ‘palliative care matters – no less now than it has ever before’. Peter’s measured, wise and insightful guidance was evidenced in his thoughtful presentation. Peter’s summation of his reflections, historical and personal perspectives, and his ongoing commitment and hope for the future of palliative care leaves us in no doubt of his future commitment to the cause.

Thank you to all the delegates who made their way to Dubbo, and who contributed to the overall success of the conference by ‘reaching out’ to other communities, communicating their desire to provide quality palliative care by connecting, networking and partnering with others as a way forward into 2013. Well done, Dubbo, and we can now look forward to the 2014 conference with Sydney firmly in the running as the host. It has been many years since our last conference in Sydney so it might be timely, but we will keep you posted of the plans as they unfold.

Adapted from *Pallium: the newsletter of Palliative Care New South Wales*, Summer 2013. Reused with permission.

Contributors wanted

DO YOU HAVE a bee in your bonnet about a palliative care issue? Have you recently attended a worthwhile conference or workshop? Or perhaps been inspired by an original research paper or book? Whether you are a trainee or a professor, we would love to hear from you!

EMAIL YOUR THOUGHTS to: executive@anzspm.org.au

National implementation of the Palliative Approach Toolkit for residential aged care facilities

New resources and staff training opportunities



By Prof Elizabeth Reymond, Clinical Director, Metro South Palliative Care Services Queensland Health

THE PALLIATIVE APPROACH (PA) Toolkit has been developed to assist staff working in Australian residential aged care facilities (RACFs) to deliver high quality evidence-based end-of-life care.

In 2009–2010, the Comprehensive Evidence-Based Palliative Approach in Residential Aged Care Project pilot-tested the PA Toolkit and aimed to increase RACFs’ awareness of evidence contained in the Guidelines for a Palliative Approach in Residential Aged Care (May 2006) and Pain in Residential Aged Care Facilities: Management Strategies (August 2005).

Recently, the Australian Government Department of Health and Ageing provided funding under the Encouraging Better Practice in Aged Care (EBPAC) initiative for a national rollout of the PA Toolkit across all Australian RACFs. This new project will focus on developing new resources and providing training opportunities that promote the development of a sustainable workforce, thus strengthening the capacity of Australian RACFs to consistently provide quality palliative care for their residents.

The 2012–2015 national rollout will:

- develop innovative clinical, educational and management resources to support the use of existing materials in the PA Toolkit. These new resources will assist RACFs to translate best available palliative care evidence into effective day-to-day clinical and operational practices

- deliver workshops across Australia for RACF managers, clinical leaders and staff trainers, focusing on how the PA Toolkit resources can be used to implement a ‘whole of organisation’ and sustainable approach to the provision of palliative care. No registration fee will be charged to attend these workshops and RACFs participating in the national rollout will receive a free copy of the PA Toolkit.

The project is being led by the Brisbane South Palliative Care Collaborative, in partnership with the Australian and New Zealand Society of Palliative Medicine, Leading Aged Services Australia, the Royal Australian College of General Practitioners, as well as the University of Queensland/Blue Care Research and Practice Development Centre. This combination of clinical, industry and professional practice leaders will allow outcomes from the national rollout to impact on and contribute to system level change.

For further information about the national rollout, please contact Gillian Davies, Project Manager, National Rollout of the Palliative Approach Toolkit, Brisbane South Palliative Care Collaborative at Gillian_Davies@health.qld.gov.au.





Australia's National Palliative Care Week: 19 – 25 May

Palliative Care Australia (PCA) has a number of resources and merchandise available to order via their website: www.palliativecare.org.au/NationalPalliativeCareWeek

IN ADDITION TO PCA's current suite of consumer resources, they have produced a brand new brochure about advance care planning. There are also pens, posters and tins of confectionary available to order for your National Palliative Care Week activities. The online ordering system will go live in early April – keep an eye on the PCA website for more details. You can also

download the National Palliative Care Week logo from the PCA website for use on your own website or other communication materials.

Due to the large number of orders received for National Palliative Care Week, it is recommended that you place your orders by **1 May** to ensure they arrive in time. Please note that

while it may take longer than usual for your order to be processed, when you place your order you will be given an indication of the timeline within which you can expect to receive your products.

If you have any questions about ordering resources please contact PCA on pcainc@palliativecare.org.au

ANZSPM beginnings



Hunter Valley: wine region

Photo: Public domain, Wikimedia Commons

An ongoing series
by Marita Linkson

Inaugural ANZSPM Conference

THE INAUGURAL CONFERENCE of the Society was held at Kirkton Park Estate, Pokolbin NSW, on 19–21 October 1994. The gathering was attended by 90 members and made a healthy \$7,000 profit.

Sessions included HIV/AIDS, Free Communications, Developments in Palliative Care, ANZSPM Discussion, Spirituality in Palliative Care, What's new in symptom control, and the Society's second AGM. The meeting also included two concurrent sessions, a poster presentation, and the Society's inaugural gala dinner!

ANZSPM's first year

During its first year of operation, ANZSPM Council held five tele-conferences, which covered a diverse range of topics that included:

- developing a close working relationship with the Australian Association for Hospice and Palliative Care (now Palliative Care Australia)
- negotiating with the Association of Palliative Medicine of Great Britain and Ireland for corporate membership at a cost of £3.00 per member (covered by ANZSPM subscriptions)
- developing relationships with COSA Palliative Care Group, NASQAC, Pharmaceutical Benefits Advisory Committee, Australian Medical Association, Royal Australasian College of Physicians,

Royal Australian College of General Practitioners, Cancer Network and the Commonwealth Department for Human Services and Health

- defining the term 'Palliative Medicine Practitioner'
- discussing ethical issues in palliative care
- debating the need for a college or faculty of palliative medicine and the issues of training, specialisation and certification
- publishing the first issue of the *ANZSPM Newsletter*
- establishing a meeting of the Society in New Zealand and directing resources towards promoting the Society amongst New Zealand practitioners.

Establishing a New Zealand branch

At the Council meeting immediately following the 1994 AGM, the Society agreed to transfer \$2,000 to **Alan Farnell** (Council member) in order to create a branch of the Society in New Zealand. A small informal meeting was subsequently held in Palmerston North on 4 November 1994, where the establishment of an education fund and plans for the second Society conference (in 1996) were discussed.

APLI

Project Hamrahi:

An Australasian Palliative Link International (APLI) and Pallium India collaboration

By Odette Spruyt
President of APLI

'I want to offer you a way to immunise yourself against meaningless travel. Imagine a situation in which you were at once in a quite other place, everything around you new, all the stimulation you wished for, and yet well supported and doing something you know to be useful. Even the food is exciting and yet safe! All the while you are being cared for wonderfully well, meeting local people, forming meaningful relationships, and experiencing a short cut to the culture. You may even be invited to speak on the local TV station. This is not a dream. This is an experience I've had many times over the last few years.'

THIS IS THE reflection of David Brumley, who travelled to Assam in 2012 with Sarah Corfe and Oliver Haisken.

David and colleagues spent a week with Iqbal Bahar and his fledgling palliative care team in Cachar Cancer Centre, in remote Assam (see accompanying letter, opposite). Their visit was organised through a collaborative project between APLI (www.apli.net.au) and Trivandrum Institute of Palliative Sciences (TIPS, www.palliumindia.org).

Since its inception in 2009, Project Hamrahi has fostered nine such visits, to six developing palliative care services, all but one in northern India, where palliative care remains in its infancy. For more information please see <http://api.net.au/projects/project-hamrahi-fellow-travellers>.

The core premise of the project is that new providers of palliative care benefit from a relationship with a more experienced practitioner, to help develop core skills and sustain commitment to serving patients who have palliative care needs. Hamrahi means 'fellow traveller'. This Hindi word was chosen to emphasise the shared journey made possible through this project. Australian palliative care practitioners have much to learn from our colleagues in India and other developing nations, whose daily exposure to suffering, grinding workloads and limited resources call for extraordinary dedication and clinical expertise. Indian colleagues benefit from the interest and attention that foreigner visits stimulate amongst their

colleagues and community, from opportunities to discuss new ways of doing things, from reduction of isolation when developing a new specialty and from the friendship that builds over repeated visits.

Opioid prescribing continues to be an extremely challenging area of practice in India, where it is estimated that less than four per cent of those with moderate to severe pain due to advanced cancer are receiving morphine.¹ Introducing patients to opioids, where opportunities for review are limited or conducted through second-hand reports from relatives, where opioid-phobia is prevalent and errors may result in heavy sanctions for the prescriber, is not a practice for the faint-hearted. Many practitioners avoid prescribing. Thus contact with practitioners with extensive experience with opioids is extremely valuable and reassuring.

I would like to sign off with the words of Anil Tandon. Anil and Wendy Scott have visited Jamshedpur, in Jharkhand state, on three occasions so far, the last visit being in November 2012. Anil describes his involvement in Hamrahi as: 'the most worthwhile project I have been involved with'.

■ Hamrahi asks for volunteer doctors and nurses to commit to at least three visits to the same service over three to five years, and for ongoing contact in between visits. If you feel you would like to participate in this, please contact Odette Spruyt on odette.spruyt@petermac.org.

Reference: 1. Human Rights Watch. Unbearable pain: India's obligation to ensure palliative care. 2009 (updated 2009 October 28; cited 2013 March 13). Available from: <http://www.hrw.org/reports/2009/10/28/unbearable-pain>

Left: Evening scene on the Brahmaputra River, Assam, India.

A visit to the Cachar Cancer Hospital and Research Centre by members of Australasian Palliative Link International (APLI) – a recent milestone

By Dr H M Iqbal Bahar
Head, Department of Pain and Palliative Care

THE CACHAR CANCER Hospital and Research Centre is a 63-bed rural centre located on the outskirts of Silchar, a town in southern Assam, India. It was established in 1996 by the Cachar Cancer Hospital Society, which comprised members from the lay community, several of whom had family members with cancer, with whom they had to travel to distant places for treatment. It is one of the two comprehensive cancer centres in the northeast of India. It serves a geographical area that is relatively less accessible and a population that is extremely poor and underserved.

The Department of Pain and Palliative Care was established in 2009 with a generous grant from the Indo-American Cancer Association. To start with, we had only a few nurses and a program coordinator, in addition to me. Since then, the department has been growing steadily with more patients pouring in and more staff being recruited. Now we have a program coordinator and ten nurses serving in the palliative care division. We run an outpatient service and a 14-bed inpatient facility.

The visit by palliative care specialists **Dr David Brumley**, **Dr Oliver Haisken** and specialist nurse **Sarah Corfe** – members of Australasian Palliative Link International (APLI) as part of Project Hamrahi – was a meaningful exercise, which in many ways helped us to realise our shortcomings, know about western methods of palliative care delivery, exchange knowledge, share common problems faced in palliative care delivery, and to break our loneliness and burnout.

Carrying out ward rounds with Dr Brumley and Dr Haisken was a rewarding experience. Seeing patients in the palliative care outpatient with them enhanced my communication skills. Home visits in remote areas with them gave me a renewed energy.

Sarah's time with the nurses was very fruitful. Sharing her experiences, she convinced the nurses that the challenges

and burnout encountered by nurses in western countries are similar to them. The nurses felt more empowered and confident after talking with her.

Human resources are the biggest problem in the region. It is difficult to find trained palliative care nurses. We therefore have had to choose ANMs and dhais (informally-trained midwives) and train them in-house. Their lack of formal training, coupled with their limited command of English and Hindi, makes this kind of training a formidable challenge.

As in previous years, an in-house six-week basic certificate course on palliative care was carried out to train nine of our nurses. This time we were glad that APLI members conducted the concluding oral and theory examination. All of the nurses passed the exam with flying colours.

One of the important aspects of the APLI team visit was local community engagement – improving the general understanding of 'what is palliative care?' This was done through media interviews on Doordarshan [an Indian public service broadcaster], by speaking to community members and NGOs of the region. The fact that doctors from overseas were talking about and delivering lectures on the importance of palliative care helped to convince the general public and medical workers that the specialty was important.

Some of the ideas suggested by the APLI team were eye-opening, such as the need for transition from inpatient care to community-based care, writing

Right: Dr Iqbal Bahar and the nurses with the APLI team. Below: Kali figure at the hospital entrance. Below right: The hospital entrance.



prescriptions in the local language, overlapping nursing shift hours to allow for teaching time, creating maps of patient residences during a home visit, and developing a neighbourhood network along the lines of Kerala (another region in India). Many of these ideas have been put into action.

We are thankful for the efforts of **Dr M R Rajagopal**, chairman of Pallium India, who helped us to bring Project Hamrahi to this remote part of our country. Our director, **Dr Ravi Kannan**, who is a surgical oncologist, was very supportive of the whole program and always inspiring and giving us ideas.

Dr David, Dr Oliver and Ms Corfe – we appreciate every bit of effort that went into your visit and all of your constructive input. Thank you also for offering to support the education of two of our nursing staff at Trivandrum. We look forward to seeing you again.

Adapted from *APLI News*, volume 16, issue 2, October 2012. Reused with permission. Photos courtesy David Brumley.



REFLECTIONS

Six weeks in Soweto: An Australian experience of palliative medicine in South Africa



South Africa has more people living with HIV/AIDS than any other country.¹ There is also a high prevalence of tuberculosis, unemployment, poverty and crime.

**By Fiona Runacres
Advanced Trainee**

HIV/AIDS IS THE leading cause of death (although under-reported officially due to inconsistent documentation on death certificates), while 'external causes' or non-natural deaths (for example, road-traffic accidents, burns and assault) were the fifth most common registered cause of death in 2008.² These factors result in South Africans dying young, with the most common age at death being 30–34 years.² Like many other countries, there exists a considerable health 'gap' between different ethnic populations.

Johannesburg, the largest city in South Africa, is a cosmopolitan city

of contrasts. Home to four million people from multiple ethnic backgrounds, speaking any of 11 national languages, it comprises the country's wealthiest and poorest citizens. Depending on opinion, Soweto is either a beloved or feared southwest township of Johannesburg, where over 1.3 million people live in sometimes very basic housing, without electricity or running water.

I learnt to 'treat what you see, with what you have' ... you [must] first address the fact that they are hungry and cold.

From May to July 2012, I had the opportunity to experience palliative medicine in Soweto through volunteering with Hospice Witwatersrand – a leading provider

of palliative care in Johannesburg. This organisation encompasses adult and paediatric inpatient units, as well as community services located in both the affluent northern suburbs of Johannesburg (Houghton Hospice), and the contrasting region of Soweto (Soweto Hospice).

Hospice Witwatersrand receives no government funding and relies entirely on community and corporate donations.

Working in the inpatient units, I learnt that good clinical assessments were sufficient in most cases, reducing my dependence on pathology and radiology, which represented luxuries that the patients could not afford. Morphine (the only available parenteral opioid) was surprisingly effective when given in end-stage renal failure, while traditional hymns and songs sung by the nursing staff were often successful in calming patients with agitated terminal deliriums that had proved refractory to haloperidol and midazolam.

Despite the relative comforts of an inpatient hospice, patients would often prefer to return home as soon as possible and local custom often required burial to occur at the person's birthplace, which could be hundreds of kilometres from Johannesburg. Relatives would often request that their loved one be transported in the last hours of life, as a public bus fare (~A\$50) was considerably cheaper than the cost of transporting a deceased's body over the same distance (~A\$1,800).



Top: Hospice Witwatersrand banner.
Left: Outside Soweto Hospice.

REFLECTIONS

Working with the community services, I visited some of the country's wealthiest and poorest people. We visited 'child-headed households' in which orphaned 15-year-old patients, experiencing symptoms of HIV/AIDS, were nonetheless responsible for their younger siblings. I learnt to 'treat what you see, with what you have' and that you cannot begin to improve a person's pain until you first address the fact that they are hungry and cold. We went on home visits armed with donated food and clothing parcels, and used peanut butter, pap and oil as an affordable, calorie-rich substitute for nutritional supplements. The power of community in Soweto was inspiring, with the majority of referrals originating from concerned neighbours. In a region of high crime, nursing staff felt safe carrying drugs and travelling alone in marked cars or on foot, due to community respect for the hospice service. However, stigma was occasionally evident, with some families declining community palliative care because they feared their house would be 'labelled' as having HIV or TB.

Practising palliative medicine internationally provides insights and experiences unattainable locally. Treating diverse diseases with reduced access to resources and medications in a foreign cultural setting compels one to modify one's approach to clinical scenarios and develop a flexibility of practice. The exposure gained from this international experience has increased my awareness of challenges affecting the provision of palliative medicine globally and furthered my appreciation of Australian practice.

I wish to acknowledge the inspiring doctors and nurses from whom I have learnt so much, and the patients of Johannesburg who graciously welcomed me into their homes and lives – with open arms, song and much rooibos tea!

References:

1. World AIDS Day report, UNAIDS, 2011. Available from: http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/jc2216_worldaidsday_report_2011_en.pdf.
2. Mortality and causes of death in South Africa, 2008: findings from death notification. Statistics South Africa, 2010. Available from: <http://www.statssa.gov.za/publications/P03093/P030932008.pdf>



Above and left: Soweto community visits.

Below: Paediatric inpatient at Soweto hospice.

JOURNAL CLUB

‘Parenteral hydration in patients with advanced cancer: a multicentre, double-blind, placebo-controlled randomized trial’

Authors: E Bruera, D Hui, I Torres-Vigil, J Trumble, J Roosth, S Krauter, C Strickland, K Unger, JL Palmer, J Allo, S Frisbee-Hume and K Tarleton.

Journal of Clinical Oncology, published ahead of print on November 19, 2012 as 10.1200/JCO.2012.44.6518

Study summary

By Chi Li
Advanced Trainee

Design:

- Double-blinded, randomised, placebo-controlled trial

Population:

- Recruited from 5 hospices in the Greater Houston area (Texas, US)
- 150 patients required to achieve 80% power with an estimated effect size of 0.5 standard deviations and an attrition rate of 15%
- Inclusion:
 - Adult hospice patients with advanced cancer
 - Reduced oral intake and mild to moderate (but not severe) dehydration and associated ‘target symptoms’
 - Several other inclusion and exclusion criteria



Photo: Public domain, Wikimedia Commons.

Randomisation and blinding:

- Computer-generated randomisation, stratified by site
- Elaborate concealment with interventions set up by separate infusion nurses
- Double-blinded: study nurses and patients

Intervention:

- 1000ml (study arm) or 100ml (control arm) normal saline infused subcutaneously over 4 hours
- Given daily until patient unresponsive, developed progressive coma or died

Measurement instruments:

- Performed at three time points: baseline, day 4 (±2) and day 7 (±2)
- Modified ESAS: pain, fatigue, nausea, depression, anxiety, drowsiness, appetite, wellbeing, dyspnoea, hallucination and myoclonus

- Numerous other instruments to assess global symptoms, myoclonus, delirium, fatigue, quality of life, dehydration
- Blood tests

Endpoints:

- Primary: change in sum of dehydration symptoms (fatigue, drowsiness, hallucination, myoclonus) between baseline and day 4
- Secondary: each individual measurement instrument, each blood test, comparing day 4 and day 7 scores to baseline, as well as overall survival

Analysis:

- ‘Intention-to-treat’: however, while 129 patients were randomised, only 102 patients were analysed

Results:

- Sample: n=129
 - Under-powered due to ‘funding limitations’
 - Higher attrition rate than expected: 21% did not receive or discontinued allocated intervention
- Baseline demographics similar between the two arms
- Primary endpoint:
 - Significant improvement seen in both arms
 - No significant difference between arms (p=0.77)
- Secondary endpoints
 - No significant difference between arms across almost all secondary endpoints (including delirium, quality of life or survival)

Invited expert commentary on the parenteral hydration study

By Doug Bridge
Clinical Professor and Head of Department of Palliative Care, Royal Perth Hospital

What was the research question?

Does parenteral hydration at the end of life produce benefit?

What do we already know?

- Dying commonly involves: decreased fluid intake, decreased perception of thirst, a dry mouth, decreased conscious state.
- There is a poor correlation between thirst, hydration, and biochemistry.

What did they discover?

One litre of saline each day did not improve symptoms, quality of life or survival.

What was impressive?

Eduardo Bruera demonstrated his usual immense energy and appetite for palliative care clinical research. In a trial lasting more than four years, the investigators gathered a vast amount of data. They even managed to disguise the infusion so that patients could not tell whether they received 1000 mL or 100 mL.

Personal observations

The introduction emphasised the harmful effect of opioid metabolites in this population. It is well-known that morphine is particularly unsuitable when there is renal impairment. I was therefore surprised to see that morphine was the commonest opioid given to patients in this study. On the other hand, I was impressed to see that methadone was also widely

used – a suitable choice in the setting of renal impairment, since it is not renally excreted.

Recruitment into this study implied a short prognosis, but one patient in the hydration group survived for eight months, and two patients in the placebo group were still alive one year later. The trial was limited to a one-week period of observation.

This study provides further evidence to support clinicians who do not routinely provide parenteral fluids at the end-of-life. However, two important limitations were noted in the discussion. Firstly, patients with severe dehydration were excluded. More surprisingly, no attempt was made to document oral intake, thereby severely diminishing the reliability of the conclusions.

At a superficial level the results of this study are contrary to expectation. When I am dehydrated my mouth feels dry and I am thirsty. So I have a drink, and my thirst is relieved. However, at the end of life our physiological processes are different, and the dehydration/thirst correlation is disrupted. Furthermore, a person facing death is challenged by social, emotional, spiritual and cultural issues, in addition to physical deterioration. All of these factors will impact on the patient's perception of symptoms and quality of life.

Bruera rightly observes: 'Frequent visits and assessments by research nurses may result in significant improvement in the perception of overall benefit, to the extent that it may even overshadow the biomedical effect of hydration.' This is a wise comment. Indeed, I would dare to paraphrase and generalise that 'tender loving care' lies at the heart of palliative care and may be of greater benefit to the patient than almost any biomedical intervention.

Historical reflection

The European hospice tradition started with the pioneering work of Dame Cicely Saunders at St Christopher's Hospice in 1967. She championed meticulous symptom control and clinical research, but also emphasised the importance of holistic care, including attention to spiritual needs.

In 1995 Dr John Ellershaw, who developed the Liverpool Care Pathway, published (with Dame Cicely) important research based on his experience as a registrar at St Christopher's Hospice. He reported the lack of correlation between hydration, biochemical tests and dry mouth/thirst in 82 patients. This reinforced the principle of 'no routine hydration' at St Christopher's.

Eduardo Bruera pioneered palliative care research in Canada, where the common practice was 'parenteral hydration for everyone'. He has published numerous papers on the topic. This paper suggests he is gradually moving closer to the St Christopher's tradition.

Current practice

At the end of life (days to weeks) routine parenteral hydration may do more harm than good.

When hydration is deemed appropriate, the subcutaneous route has proven very simple and convenient. It can be administered at home without any machinery or monitoring of the rate. One litre per day is traditional. Adding hyaluronidase (previously promoted by Bruera) to hasten diffusion is unnecessary.

JOURNAL CLUB

‘Early palliative care in advanced lung cancer: a qualitative study’

Authors: J Yoong, ER Park, JA Greer, VA Jackson, ER Gallagher, WF Pirl, AL Back and JS Temel.

JAMA Intern Med
2013;173(4):283-290.

Study summary

By Jaclyn Yoong
Medical Oncologist and
Palliative Care Physician,
The Northern Hospital

IN 2010, THE *New England Journal of Medicine* published a groundbreaking study entitled ‘Early Palliative Care for Patients with Metastatic Non-Small-Cell Lung Cancer’ by Temel and colleagues. This randomised clinical trial found that patients with newly diagnosed advanced lung cancer who received early integrated outpatient palliative care and cancer care had better quality of life outcomes and mood, and lived longer than those who received standard oncology care alone.

This follow-up study, published earlier this year in *JAMA Internal Medicine*, sought to explain what the palliative care clinicians did that may have accounted for the benefits observed. The aims of the secondary qualitative analysis were to firstly, identify the key elements of early palliative care clinic visits; secondly, explore the timing of these key elements over the trajectory of illness; and thirdly, compare the content of palliative care and oncology visit notes at the critical time points of clinical deterioration and radiographic disease progression.

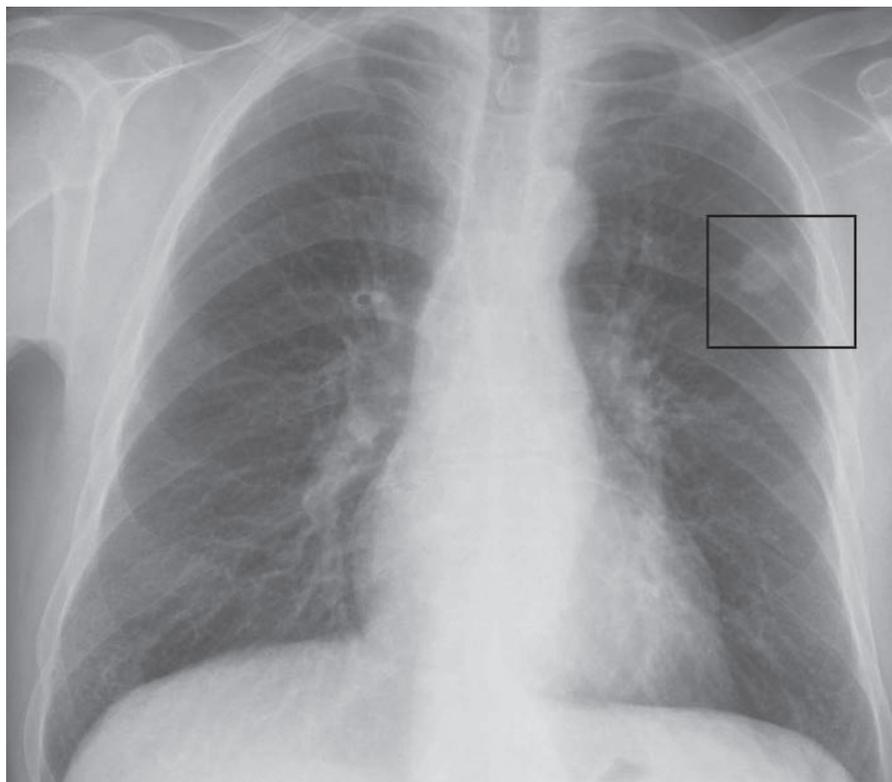


Photo: Lange 123 at the German language Wikipedia

Twenty patients were randomly selected from the intervention arm. Content analysis of the visit notes was performed through application of grounded theory, iterative process of review and coding using NVivo9, a qualitative analysis software package.

The results showed that addressing symptoms and coping were the most prevalent components of the palliative care clinic visits. Initial visits focused on building relationships and rapport with patients and their families and establishing illness understanding, including patients’ information preference and prognostic awareness. Goals of care and hospice discussions predominantly occurred during later visits. Comparing palliative care and oncology visit notes around critical time-points, both included discussions about symptoms, illness status and goals of care; however

palliative care visits emphasised psychosocial elements, while oncology visits focused on specific cancer treatments and management of medical complications.

In summary, early palliative care clinic visits appeared to focus on key elements such as relationship and rapport building, establishing illness understanding, addressing symptoms and coping, discussing cancer treatment, end-of-life planning and engaging family members, with varying emphasis on particular elements at different times along a patient’s disease trajectory. There seemed to be distinct yet complementary roles for palliative care physicians and oncologists at critical turning points. Palliative care involvement may enable oncologists to focus on anti-cancer management.

Invited expert commentary on the early palliative care study

By Prof Janet Hardy
Director Palliative and Supportive Care, Mater Health Services, and

Prof Patsy Yates
Professor of Nursing, Queensland University of Technology

THIS PAPER IS a companion piece to the much quoted paper by Temel et al¹ that documents the benefits of early referral to palliative care (PC) in those with advanced lung cancer. Patients randomised to early PC had significant improvements in both quality of life and mood, less aggressive care at the end of life and a longer survival. The authors suggest that the integration of PC with standard oncologic care in the ambulatory setting may have a different emphasis compared to traditional PC delivered as an inpatient or consultative service. The purpose of this study was to tease out 'the salient elements of clinical encounters with palliative care ... by exploring the content of clinical visits'.

In the Temel trial, PC clinicians documented the content of the clinical encounter in an electronic health record. In this study, the clinical documentation of those in the intervention group (early PC) was analysed to determine key themes. These themes were compared to those identified from the records of oncologists at specified time points along the disease trajectory, from initial diagnosis of metastatic disease until death.

Seven key elements were identified and, not surprisingly, different elements were emphasised at different phases of the disease. Relationship and rapport building, establishing illness understanding and discussions regarding the effect of cancer treatment were prominent in the earlier encounters. Efforts to optimise symptoms and coping, illness understanding and family engagement took place throughout. End-of-life planning and discussions around further anti-cancer treatment featured in later visits. Themes identified from PC notes often had a different focus than those identified from oncological encounters.

The authors propose that the clinical components identified may serve as a useful foundation for developing a framework for the provision of ambulatory services in the future. They also point to the distinct yet complimentary roles of oncology and PC in the care of patients with advanced cancer.

There are obvious limitations in this study. While the authors used a rigorous approach to ensure reliability of coding, a retrospective analysis of documentation is always limited by the quality and completeness of that documentation. Similarly, it does not capture nonverbal communication or encounters with other clinic staff.

Is it appropriate to generalise the findings from a single institution in Boston to all settings? The study has a small sample size of only 20 cases in total, examining five patients from each of the four survival periods (<3, 3–6, 6–12 and > 12 months). It is stated that this was sufficient for thematic saturation but the potential for bias is substantial.

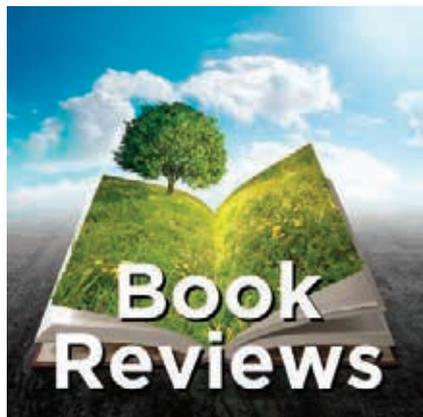
The concept of saturation is problematic in situations where there is considerable diversity of individual experience and circumstances. Additional codes and themes were added by the authors during the analytic process. With no opportunity to interview or record encounters prospectively, it is likely that critical elements of the interactions between health professionals and patients have not been identified in this analysis.

This research could be considered as a retrospective audit, rather than a qualitative study. It would not seem unreasonable to have audited all of the cases, as the intervention group comprised only 77 patients in total. Moreover, as the PC clinicians in the Temel trial were advised to follow specific guidelines, this study may be seen as an audit of how well they conformed to those guidelines.

As a clinician working in an environment comparable to the study setting, it was interesting to see that the themes identified by the authors were also reflected in my routine practice, specifically the initial rapport building, the difference in focus from oncologists, and the natural transition towards end-of-life planning as the disease progresses. However, in centres where this is not the case, whether the evidence from this paper is strong enough to change practice remains to be seen.

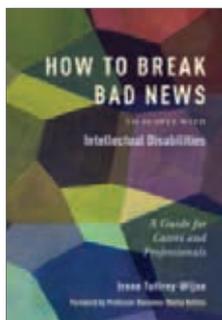
Reference: 1. Temel JS, Greer J, Muzikansky A, Gallagher E *et al*. Early palliative care for patients with metastatic non-small cell lung cancer. *N Engl J Med*. 2010;363:733-42.

BOOK REVIEW



How to Break Bad News to People with Intellectual Disabilities: A guide for carers and professionals

**By Irene Tuffrey-Wijne
Foreword by Professor
Baroness Sheila Hollins**



Jessica Kingsley
Publishers
2012, 192pp.
ISBN
978-1-84905-280-1

THIS IS A remarkable book. It aims to give 'guidance about how to support someone

with intellectual disabilities in bad news situations' and as such will be helpful to anyone who provides or commissions care for, or cares about, someone with an intellectual disability. It provides a framework for approaching the discussion of bad news situations and gives numerous rich examples based on in-depth research that involved the experiences of those with intellectual disabilities, their families and friends, professional caregivers and health professionals. In addition, it provides a challenge to the way in which we think about and talk about bad news in many other contexts and as such is thought-provoking and potentially practice-changing.

The book is divided into four sections followed by a number of useful appendices. A central thesis to this book is that talking about and coming to understand bad news is a complex process and not a one-off or a linear event. Critical to how information is imparted is a prior understanding of the knowledge base of the person with whom the news is being discussed. The steps taken to build on this knowledge base need to be at a rate and level determined by each individual's understanding and needs. Involving those who care about and for the person with intellectual disability is key, not only because of the understanding that they already have about that person, but also because they are likely to play a significant role in helping develop the knowledge base and support the process of integrating the 'bad news' and its implications.

Talking about and coming to understand bad news is a complex process and not a one-off or linear event.

The first section of the book provides a background to understanding intellectual disability, capacity and what bad news is – about all of which it is easy to make assumptions. It then discusses why current communication guidelines about breaking bad news may not be adequate to manage bad news situations for people with intellectual disability – hence the need for new guidelines.

The second section describes the guidelines and their underlying principles, including the need to find out who knows and cares about this person and may already understand their knowledge base, and how to build on it. It also discusses why providing support for these carers is a very important part of the process.

The third section addresses the guidelines in more detail. It addresses issues such as: 'Who can give chunks of knowledge?' and questions such as: 'Who should be told first?' and 'Am I allowed to tell him?' It provides advice when situations are particularly complex such as when caregivers disagree about discussing bad news with someone: 'I would lie to protect him', or when there is sudden bad news, such as a death that someone needs to be told about quickly.

The fourth section gives examples of three different bad news situations: being diagnosed with cancer; needing to move to a new residential care facility; a friend and housemate entering the later stages of dementia. These examples start with establishing the person's existing framework of knowledge to help everyone see what chunks need to be added now, what can and must be added later, what chunks are not necessary for this person and how big each chunk should be. The examples are moving and illuminating. They demonstrate vividly how much difference it can make to have such a framework within which to support someone through events that are changing their life.

In summary, this book is a pleasure to read. It follows its own central thesis by gently establishing and then building on a foundation of knowledge so that by the end of the book the reader has a robust framework for communicating with those affected by intellectual disability. The guidelines it teaches are deeply rooted in the experience of those affected by intellectual disability whose voices powerfully support the learning. In addition, the book thoughtfully challenges assumptions about discussing bad news and promotes a framework that is in fact widely applicable in many other settings. I would recommend it for those who care about and for people with intellectual disability, which should include everyone in healthcare.

Reviewed by Anne O'Callaghan

Positions Vacant

Consultants, Palliative Medicine

Auckland Hospital Palliative Care Service, New Zealand

Reference No. 042524

Applications close 31 December 2013



Expressions of Interest Positions available from 2014

The Auckland Hospital Palliative Care Service is looking for expressions of interest in Consultant posts in hospital palliative medicine. These posts will become available in 2014.

Auckland Hospital is a large tertiary institution and is a teaching hospital of the University of Auckland with active undergraduate and graduate programs.

You will have the opportunity to work in an expanding palliative care team that includes nurse specialists, a nurse practitioner, advanced trainees, rotating registrars and LCP facilitators. The team is actively involved in teaching and research activities, as well as service development projects regionally and nationally.

To apply for this specialist post you require FACHPM qualification or a recognised equivalent (i.e. have completed at least a three–four year advanced training programme in palliative medicine) and must be eligible for vocational registration with the New Zealand Medical Council. For details regarding registration, please visit www.mcnz.org.nz.

In addition to a great job, the natural beauty of Auckland and New Zealand offers you a wide range of lifestyle opportunities including sailing on the Auckland Harbour, easy access to many beaches, the New Zealand native bush and snow covered mountains.

ADHB is an accredited employer with NZ Immigration service, so we can help with your immigration requirements and can also provide relocation assistance.

For further information:

Please contact Dr Anne O'Callaghan, Clinical Director, email: anneo@adhb.govt.nz

To apply:

Please apply online at www.careers.adhb.govt.nz and quote job reference number 042524 to attach your updated CV and a covering letter.

For assistance or a copy of the position description, please contact Esther Bathula, Recruitment Consultant on +64 9 639 0211 or email: esther.bathula@adhb.govt.nz

Closing date: Tuesday, 31 December 2013

ADVERTISEMENT

Position Vacant**Palliative Medicine Registrar****Otago Community Hospice, Dunedin****Position available from December 2013****Applications close 26 April 2013**

The Otago Community Hospice is located in Dunedin, a vibrant university town in the South Island of New Zealand. Dunedin is only three hours away from Central Otago and Queenstown and has on its doorstep adventure tourism, winter sports, winemaking regions, tramping and much more.

The Otago Community Hospice provides community-focused specialist palliative care and is based in Dunedin, with an outreach programme serving North, South and Central Otago. A 12 bed inpatient unit is located in Dunedin. The service is fully committed to an interdisciplinary approach. There is a strong relationship with Otago Medical School, Dunedin Public Hospital, including the hospital palliative care team and other community services.

The Otago Community Hospice has a full time registrar position that will become vacant in December 2013 and is looking for medical practitioners interested in palliative medicine for a twelve-month post. A shorter term would be considered.

The position is suitable for advanced training in palliative medicine with the RACP Chapter of Palliative Medicine. The position would also suit general practitioners, rural doctors and other practitioners interested in learning more about specialist palliative care.

The registrar would work across the Hospice services, with a focus on the inpatient unit. They would be medically responsible for the day-to-day management of patients and be supervised by the Medical Leader.



It is essential that applicants have excellent communication skills, a continuous improvement focus and total commitment to collaborative teamwork.

We are fully committed to providing ongoing professional development opportunities for all staff and offer excellent working conditions.

For further information:

Please call Ginny Green, CEO, on 00 64 3 473 6005 or email ginny.green@otagohospice.co.nz. All enquiries will be treated in the strictest of confidence.

Applications close 26 April 2013.

The Australian & New Zealand Society of Palliative Medicine Inc. presents the 2013

MEDICAL & SURGICAL UPDATE FOR PALLIATIVE MEDICINE

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

INVITATION TO ATTEND

It gives me great pleasure to invite you to the second ANZSPM Medical and Surgical Update for Palliative Medicine. Following the success of the inaugural meeting in 2011, we would like to continue the tradition of an interactive style meeting, which will provide state-of-the-art updates for areas relevant to doctors and nurse practitioners who work in, or have an interest in, palliative medicine. This meeting will cover 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.

Assoc. Prof. Mark Boughey, Conference Convener



PROGRAM OUTLINE

FRIDAY 28 JUNE

Arrival tea & coffee

Endocrinology Update

Morning tea

Haematology Update

Lunch

Psycho-oncology Update

Afternoon Tea

Interventional
Gastroenterology &
Radiology Updates

SATURDAY 29 JUNE

Trainee Breakfast

Intensive care Update

Morning tea

Cardiology Update

Lunch

Emergency Update

Afternoon Tea

Infectious Diseases update

WITH THANKS TO OUR SPONSOR



REGISTRATIONS NOW OPEN

We are delighted to announce that registrations are now open. You can download the registration brochure from the Conference website (www.anzspm.org.au/update2013) – we suggest you read through this document prior to registering.

You have two ways to register for the Conference. You can register online via the conference website and click on the link to start the online form (preferred method) or you can complete the registration form attached to the registration brochure and post, email or fax it back to the Secretariat.

www.anzspm.org.au/update2013

PO Box 180, Morisset NSW 2264

Tel: +61 2 4973 6573 Fax: +61 2 4973 6609

Email: anzspm@willorganise.com.au

ANZSPM

CONFERENCES & EVENTS

Conferences & Events Calendar

Palliative Care Forum

(PCC NZ, Hospice NZ, Ministry of Health)

• 3 April 2013, 1.30pm – 4.30pm, Hamilton

ALSO: 9 Apr 2013, Palmerston North • 16 Apr 2013, Christchurch • 23 Apr 2013, Videoconference
Contact Heidi Goosen, heidi_goosen@moh.govt.nz
Ph. +64 4 496 2440

12th National Rural Health Conference: Strong Commitment, Bright Future

7-10 April 2013 | Adelaide, SA

www.nrha.ruralhealth.org.au

Spiritual Care Australia Conference

15-17 April 2013 | Brisbane, QLD

Spiritual Care Australia website

Forum for Medical Trainees considering a PhD

18 April 2013 | Melbourne, VIC

6.00 pm for 6.30-8.00 pm

Contact: Jenni Harris, e: ctc@wehi.edu.au, ph: 03 93452480

Compassion and Presence

18-19 April 2013 | Brisbane, QLD

www.spcare.org/en/edu/events-au.html

3rd International Public Health and Palliative Care Conference (Death, Dying, Loss & Care – social experiences or medical events?)

25-27 April 2013 | Limerick, Ireland

www.publichealthpalliativecare.org/index.html

ANZSPM/ACHPM Trainee Day

3 May 2013 | Sydney, NSW

Registrations now open: www.anzspm.org.au

Pain Management in Palliative Care Symposium

4 May 2013 | Sydney, NSW

Registrations close 27.04.13: http://sydney.edu.au/medicine/pmri

4th International Society of Advanced Care Planning and End of Life Care Conference

9-11 May 2013 | Melbourne, VIC

www.acpelsociety.com/conference/

Activity Based Funding Conference 2013

13-16 May 2013 | Sydney, NSW

Sydney Convention and Exhibition Centre
www.abfconference2013.com/

National Palliative Care Week

19-25 May 2013

Palliative Care Australia has a number of resources and merchandise available to order via their website:
www.palliativecare.org.au/NationalPalliativeCareWeek



Compassion and Presence

20-21 May 2013 | Melbourne, VIC

www.spcare.org/en/edu/events-au.html

RACP Future Directions in Health Congress 2013

26-29 May 2013 | Perth, WA

www.racpcongress2013.com.au/

ANZSPM is presenting a Palliative Medicine session as part of the Physicians as Medical Experts Stream on Tuesday, 28 May 2.00pm-3.30pm

13th World Congress of the European Association for Palliative Care

30 May – 2 June 2013 | Prague, Czech Republic

www.eapc-2013.org/

Compassion and Presence

20-21 June 2013 | Sydney, NSW

www.spcare.org/en/edu/events-au.html

ANZSPM Medical and Surgical Update for Palliative Medicine

28-29 June 2013 | Melbourne, VIC

Registrations Open – Early Bird closes 24 May 2013

www.anzspm.org.au/Update2013 – see page 23

5th International Conference on Ageing and Spirituality

7-10 July 2013

www.fiop-mha.events-made-easy.com

Inaugural National Palliative Care Research Colloquium

18-19 July 2013 | Melbourne, VIC

★ Save the date http://centreforallcare.org/index.php/news/entry/inaugural_national_palliative_care_research_colloquium_july_18th-19th_2013/

ANZSPM Aotearoa Annual Meeting and Education Day

20-21 July 2013 | Wellington, NZ

★ Save the date Brentwood Hotel, Wellington

PaCCSC/ACORD Concept Development Workshop

2 September 2013 | Canberra, ACT

★ Save the date Contact Rhiannon Haines
Email: paccsc@flinders.edu.au, ph 08 8275 1926



ANZSPM/ACHPM Trainee Day

★ Save the date 3 September 2013 | Canberra, ACT

PaCCSC/SuperEgo Cafe Critical Appraisal Workshop

3 September 2013 | Canberra, ACT

★ Save the date
www.dccferences.com.au/apcc2013/Home



12th Australian Palliative Care Conference

3-6 September 2013 | Canberra, ACT

www.dccferences.com.au/apcc2013/



Health Professionals' Health Conference 2013

3-5 October 2013 | Brisbane, QLD

www.hphc2013.com.au

Abstract Submission opens 1 February 2013

APHC 2013: 10th Asia Pacific Hospice Conference

11-13 October 2013 | Bangkok, Thailand

http://aphc2013.com/

Abstract Submissions Close 26 April 2013

The First International Congress on Whole Person Care

17-20 October, 2013 | Montreal, Canada

www.wpc2013.ca/

Poster presentation submissions Close 31 May 2013