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Family doctor involvement in palliative care: What's its prognosis?



By Brett Montgomery
General Practitioner
Western Australia

I FEEL LIKE such a fraud. What am I doing writing about palliative care, when I am a doctor who rarely provides palliative care? My justification for writing is that it's this very sense of uncertainty and under-qualification that I'm feeling which is the subject of my article.

I'm a general practitioner (GP), also known as a family physician or family doctor. GPs have a special place in many health systems. We're the primary care doctors. We're often the first point of contact for people in the health system. We welcome patients regardless of age or gender. We don't just diagnose and treat disease; we try to prevent disease too, and also act as coordinators of care for patients with complex health needs. Our work emphasises continuity of care – we build relationships with patients over time, which helps to build trust and enrich the care we provide.

Ideally, we treat whole people, not just diseases, and we see our patients in the context of their family and their society. Of course, good doctors from other disciplines will do this too, especially good palliative care specialists – GPs don't have a

monopoly on this sort of holism. But if we're not practising like this, then we're arguably not being good GPs.

I mention all of the above to summarise some of the defining features of general practice. But many would argue that providing palliative care is also an important feature of well-rounded general practice. John Murtagh, in his classic textbook on general practice, writes:

The GP is the ideal person to manage palliative care for a variety of reasons – availability, knowledge of the patient and family, and the relevant psychosocial influences. A key feature is the ability to provide the patient with independence and dignity by managing palliative care at home. Someone has to take the responsibility for leadership of the team and the most appropriate professional is a trusted family doctor.¹

But are GPs embracing this challenge? Decreasingly so, it seems. The rate of home visits halved in Australian general practice between the nineties and the noughties; I think it's a fair bet that GP home visits for palliative care fell in some similar proportion. In 2007, a quarter of Australian GPs surveyed said they were not involved in palliative

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The Australian & New Zealand Society of Palliative Medicine
Perth WA, 8-11 September 2016
The changing landscape of Palliative Care

ANZSPM

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Editor's Note
Chi Li

THE THEME OF the upcoming ANZSPM 2016 Conference is 'The Changing Landscape of Palliative Care'. One of the big changes over the past twenty years has been the development of palliative medicine as a subspecialty. It has arguably lead to better specialist training and more robust research. But has it also led to the de-skilling of our colleagues?

In this issue's feature article, **Brett Montgomery**, a general practitioner from Western Australia, ponders how recent changes in the palliative care landscape have affected his role in caring for patients at the end of life. In response, **Ian Maddocks**, **Geoff Mitchell**, **Karen Cooper** and **Michael Chapman** share their thoughts as well. How we get the balance right between specialist and generalist palliative care is an important discussion that we need have as a specialty. I encourage all of our readers to reflect on their own practice, talk to their colleagues, and perhaps even write a comment to the original Palliverse blog post, message Brett directly on Twitter, or drop me a line at chi.li.australia@gmail.com.

Elsewhere in the Newsletter, we examine two recent papers from the *Journal of Clinical Oncology*: one looking at the use of pregabalin in combination with radiotherapy for malignant bone pain; and another exploring the implications of prognostic discussions between oncologists and their patients. **Ofra Fried** reviews Judith Murray's new book on grief: 'Understanding loss: a guide for caring for those facing adversity'. We also have the usual updates from our president **Carol Douglas** and Aotearoa Branch Chair, **Amanda Landers**, plus a letter from **David Brumley** about **Doug Bridge's** spirituality workshop earlier this year. Enjoy!



President's Report

Carol Douglas

WHEN EMBARKING ON the course to set up a forum to start a conversation regarding euthanasia and physician assisted death amongst our discipline, I believed that there was an urgent need for the opportunity to facilitate this dialogue. Importantly, our current trainees and future specialists need the opportunity to speak freely with senior colleagues and gain a greater understanding of the complexity of physician assisted death.

Currently, Australian media is bombarding the public and reminding them of their unassailable right to choose the method and timing of their dying, in a bid to support legislation for such.

Certainly the public is fascinated by the discussion and drawn in by the compelling arguments of seemingly compassionate and caring media personalities and assisted dying advocates – yet it would seem that, at least in Australia, the wise words of a palliative medicine specialist whose experience should 'hold significant weight' may not always be heard.

Perhaps the opportunity for the public to talk about euthanasia and physician assisted death reflects the 'starved' public's need to express their concerns

and wrestle back control from a medical system that continues to treat at any cost in the face of dying.

Just as in our broader societal settings, this is an emotive and divisive issue for palliative medicine specialists. There are those amongst us who would prefer that we did not engage in this debate; and others who believe that the opportunity for patients to seek such support in assisted dying remains a patient's right.

The broader medical community interest is reflected in the setting up of a Royal Australasian College of Physicians Euthanasia and Physician Assisted Death Working Party, which will be convened shortly. ANZSPM anticipates appropriate representation from our specialty from those who have generously responded to the expression of interest.

ANZSPM Council is very grateful for the enthusiasm and energy of all who contribute to such important work. The need to establish our position statement and clinical guideline for palliative sedation is well advanced and we are aiming for publication during 2016. This work will greatly inform our specialty and the broader medical community regarding practices that can often be misrepresented in the broader debate regarding euthanasia and physician assisted death.

Finally, compassion must not be confused with a lack of competence in care of the dying. The larger response for our society will be powerful advocacy for enhanced palliative care services and equity of access across Australia and New Zealand.

CONTRIBUTORS ALWAYS WELCOME

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



'Coming together is a beginning; keeping together is progress; working together is success.'

– Henry Ford

CHRISTMAS 2015 has come, gone, and become a distant memory. Meetings and committees start with a vengeance in February and it sometimes feels like patients squeeze in around the multitude of work-related gatherings.

ANZSPM Aotearoa continues to strive to represent its members both at a local level and nationally. Together with Care Alliance, many ANZSPM representatives continue to raise the profile of palliative care and quality end-of-life care in different parts of New Zealand. Our goal was both awareness but also encouragement to New Zealanders to have their say and put a submission into the Health Select Committee who are investigating the desire to end one's own life. The submission process closed on 1 February and we now await the outcome. It has been made clear by John Key, the New Zealand Prime

Minister, that this process will inform but not lead to law change.

On 5 March, the second Trainee Day sponsored by ANZSPM Aotearoa will happen. We have a great programme planned with a few Australian trainees taking up the opportunity to come and network with colleagues 'across the ditch'. Peter Kirk, originally from Canada but now working in the Waikato region, has been appointed as the National Trainee Facilitator. Feedback from trainees so far has been very positive. Unfortunately, we were not successful in the Genesis Oncology grant round, but further discussion about financing this position will take place later in the year.

The concept of a national umbrella organisation to represent the palliative care sector continues to evolve. The interim group has agreed on some terms of reference and has looked around the world for possible models that may be 'retro-fitted' for the New Zealand landscape. The provisional name mooted for the organisation is: 'Palliative Care Alliance of New Zealand' (PCANZ). ANZSPM members will hopefully be hearing more about this exciting new initiative in the near future.

At the most recent face-to-face Council meeting in Melbourne, Carol Douglas and I signed the updated Memorandum of Understanding between ANZSPM and the Aotearoa branch (see accompanying photo),



which clarifies our respective roles and responsibilities. Although not scintillating reading, the Memorandum is vital for the governance and accountability of ANZSPM Aotearoa – and it was really great to be able to tick it off my to-do list!

As a heads-up, the ANZSPM Aotearoa Executive has decided to hold this year's Annual Education Day in Auckland for a change. It will be held on 2–3 July, following the Trainee Day on 1 July. We have already tweaked the programme to liven things up a little! Please pencil these dates into your diary, as the more the merrier!

From the land of mountains and seas – Amanda.



The Australian & New Zealand Society of Palliative Medicine Incorporated is a not-for-profit specialty medical society for medical practitioners who provide care for people with a life threatening illness.

Our members enjoy:

- Networking opportunities with fellow members
- ANZSPM Newsletters – published three times per year and including educational and interesting articles relevant to palliative medicine practitioners
- ANZSPM E-Update – our regular electronic updates to members with the latest palliative medicine news, research and events
- Reduced registration fees at our biennial conference and other education forums and seminars

- Reduced subscription fees to some palliative medicine journals
- Opportunities to influence policy affecting palliative medicine practitioners.

FOR MORE INFORMATION OR TO JOIN ON-LINE:

Please visit www.anzspm.org.au or contact ANZSPM's Executive Officer, ph +61 458 203 229 or email executive@anzspm.org.au

FEATURE

Family doctor involvement in palliative care: What's its prognosis?

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care, and these GPs tended to be younger, working part-time, and not practice owners.² These demographic features are becoming more common, which invokes the spectre of GP palliative care participation falling further.

Roger Ladouceur, troubled by even more dramatic figures from Canada, wrote last month:

How is it possible to be a family physician who espouses the 4 principles of family medicine but refuses to visit patients at home when they are too sick to come to the office? How can we say that 'family medicine is a community-based discipline' or that 'the family physician is a resource to a defined practice population' if we refuse to provide care to patients in their homes – especially end-of-life care?³

All of this is enough to make me feel guilty and inadequate. I don't personally have a blanket rule against doing palliative care or home visits, but I admit these happen rarely for me. My home visits are usually longstanding patients who used to see me in my clinic, but who have become incapacitated by multi-morbidity, often after an acute exacerbating event that has seen them hospitalised, then precariously discharged. Indeed, for some of these patients with poor prognoses, I'm arguably providing a type of palliative care – the sort that exists 'beyond cancer'⁴ – though I tend to think of this work as 'GP geriatrics' rather than 'GP palliative care'.

But for patients with advanced cancer who are clearly going to die of their disease, referral to a palliative service is my usual action. I am lucky to practise in a region where quality palliative care services are available and responsive. If I tried to provide comprehensive palliative care myself, I fear I'd feel unsupported and like something of an

imposter. Sure, I can try to prescribe analgesia rationally, to understand my patient's goals, and to embark on conversations about symptom control instead of cure. But will I feel out of my depth as opiate doses escalate? Will I remember to screen for symptoms other than pain? What if these symptoms are refractory to first-line treatments? Will I know what to do? Will I fail to consider some available palliative options, like radiotherapy for bony malignancies? I'm not part of a palliative team, sharing rosters with other doctors, and working alongside experienced palliative nurses. Is it realistic to go it alone? Do I have to be 'on call' for my patient and their family around the clock? What does this mean for my availability for my own family? Won't my patients get better care from people who do this often, together, rather than from someone who does it infrequently, alone?

Perhaps I'd feel more confident in my knowledge if I'd had dedicated palliative care experience as a junior hospital doctor.

When I refer my patients to palliative care services, I don't mean to abandon them. I remind them that despite this referral, I will remain their GP and am happy to see them as needed. But in reality, I seem to see these patients on few further occasions, and have little if any input into their palliative care.

My anxieties are not unique. The survey above found that barriers to GP palliative care participation included perceived lack of knowledge, a disinclination to do home visits, and difficulty being available out-of-hours due to family or personal commitments.² Geoff Mitchell and colleagues discuss such barriers

further.⁵ In terms of knowledge, they describe the sporadic nature of palliative cases in general practice, the evolving palliative care evidence base, and competing educational priorities as conspiring to diminish GPs' knowledge and confidence. They identify barriers to home visiting including safety concerns and time and cost inefficiencies. GP undersupply or maldistribution is another possible barrier they mention. And they also cite the 'specialisation' of palliative care as another barrier: an 'unclear role definition for GPs in specialist palliative care service environment or among multiple service providers with palliative care brief'. All of this rings true to me.

Other barriers aside, perhaps I'd feel more confident in my knowledge if I'd had dedicated palliative care experience as a junior hospital doctor, or during my GP training years. It's tempting to think this would be true. But research published last month in *Canadian Family Physician* calls this into question.⁶ Interviewed after a 4-week palliative care term, family medicine residents reported feeling discouraged from future palliative care work. This was not because it was a bad educational experience – on the contrary, they praised its usefulness in reinforcing communication skills and improving their knowledge of symptom management at the end of life. But they were left lacking in confidence in their ability to do this sort of work independently, because it was seen as specialised and highly skilled. To quote the authors:

Our findings also highlighted that despite the curricular goal of new graduate engagement in palliative care, the delivery of the curriculum has the unintended effect of discouraging family medicine residents (FMRs) from incorporating palliative care into their future practices. Our study suggests that this disjuncture might ... result from a misalignment between learners

and the most appropriate mentors. A palliative care rotation created for FMRs in which educators are part of a specialised program might reinforce the notion that palliative care is best offered by palliative care specialists...

Additionally, minimal exposure to family medicine preceptors who incorporate palliative care into their practices contributes to residents' disempowerment in the provision of palliative care.

When combined with feelings of discomfort stemming from insufficient palliative care skills and lack of clarity around how to integrate palliative care into a family practice, FMRs were faced with a dilemma: Although they greatly valued the physician-patient relationship that developed over time, many FMRs also felt obligated to refer their dying patients to specialised palliative care programs, which were perceived as providing better care owing to more expertise and appropriate infrastructure.

These are important and disappointing findings for those who hope to see greater GP engagement with palliative care.

What are the solutions? If budding family doctors are to feel inspired and confident, perhaps palliative care needs to be role-modelled by experienced family doctors, rather than palliative medicine specialists. But opportunities for this role modelling may be scarce, given the infrequent engagement in palliative care of most GPs.

Is the prognosis for GP palliative care terminal? For the classical palliative care we see in advanced cancer, in regions where specialist services are easily available, the outlook is at best uncertain. Does this matter? Some patients may prefer the availability and expertise of a specialised service. Others may have preferred the continuous care of a known doctor – one who is a specialist in *them*, if not a specialist in palliative care.

In regions (particularly rural areas) with less access to specialised palliative care, I suspect GP involvement in palliative care work will remain very important. And as for palliative care 'beyond cancer', many GPs may already be doing more of this than they realise, even if, like me, they have been framing it in different language.

Where to from here? I don't have the answers, but I look forward to the conversation. What do you think?

This article is an abridged version of the original, which was first published on Palliverse in January: <http://palliverse.com/2016/01/06/family-doctor-involvement-in-palliative-care-whats-its-prognosis/>

You can join the conversation by posting your comments on the Palliverse blog, contacting Brett on Twitter (@brettmontg) or writing to the ANZSPM Newsletter editor (chi.li.australia@gmail.com).

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Family doctor involvement in palliative care: What's its prognosis?

Responses to the feature article

Response from Karen Cooper ANZSPM Project Manager, Decision Assist

I AM THE project manager for the GP Palliative Care Education and Resources project being conducted by ANZSPM, as part of Decision Assist. As many of the Newsletter's readers will know, Decision Assist is a program funded to enhance the provision of palliative care and

advance care planning services to the aged nationally. Brett's piece reminds me how important it is for us to share this work and the supports it provides to GPs and those working in aged care across the nation.

We have developed many educational activities and resources for GPs based on a palliative care framework of care developed by ANZSPM. The framework of palliative care is a tool that uses three prognostic trajectories to help GPs to proactively manage their patients' care as it transitions from curative to palliative, and to facilitate a quality end of life according to patient

preferences. The framework is outlined in a recent article in *Australian Family Physician*.¹

Education activities utilising this framework include a workshop, an online module (as an alternative to the workshop) available through Rural and Remote Medical Education Online (RRMEO) and gplearning, an end-of-life clinical audit, and an Active Learning Module (RACGP)/Theory Practice Activity (ACRRM). These activities have been accredited by both RACGP and ACRRM.

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FEATURE

Responses to the feature article

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Other non-accredited activities include videos about managing four common palliative care symptoms (pain, nausea and vomiting, dyspnoea and delirium), plus an online case-of-the-month discussion. Details of these education activities can be found at: www.caresearch.com.au/caresearch/tabid/3227/Default.aspx

A few more words about the end-of-life clinical audit: feedback from GPs suggests that many find it very useful, helping to increase their confidence in managing patients at the end of life. Interestingly, the average age of patients in the completed audits is 81 years, and the majority of these patients died from one or more non-malignant conditions.

Other Decision Assist resources that GPs may find useful include:

- a 24-hours, 7-days-a-week phone line that connects GPs directly with a large specialist palliative care service. GPs can talk directly to a palliative medicine specialist by ringing **1300 668 908**
- a free smartphone app for GPs: palliAGED, available for download
- advanced care planning workshops.

For more information about GP palliative care education activities and resources, please visit the Decision Assist website: www.caresearch.com.au/caresearch/tabid/2583/Default.aspx

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Response from Michael Chapman, Palliative medicine physician and geriatrician, Calvary Health Care ACT

UPON REFLECTING ON Brett's piece and many of the comments on Palliverse, I am conscious of the limits of what specialist practice can provide, and how much palliative care is being expertly practised, day-in day-out, by GPs, other specialists doctors, trainees, nurses, aged care staff and community members. So many people are involved in providing (and receiving) palliative care, even if it is not explicitly stated. Because so much of palliative care is fundamentally good, person-centred care for someone with advanced illness, it is easy to overlook the skills that many of us have and use, without ever consciously acknowledging them as 'palliative care skills'. As a palliative medicine specialist, I think my job is often to point out to all of these people providing this care (including GPs) that they are doing a great job already.

In saying that, I think it is also important to acknowledge that, even as a specialist, I still get that feeling of discomfort when I am unable to control these situations for patients and families.

Therefore, as a clinician, if you feel a bit 'at sea' when supporting people at the end of life, I don't think this means you are necessarily doing it wrong. While it is possible to become more confident with many aspects of managing death and dying, it never gets easy. With experience, I think you do get more comfortable with being uncomfortable, but we all need support in doing this work – even if this simply involves running some thoughts by another clinician.

With supports such as Decision Assist, all primary care clinicians can now access specialist support by phone regardless of their local setup, which I think is an important step forward.

As Brett points out, the realities of our healthcare system mean that the many needs of a person approaching end of life are difficult to meet without the support of a multi-disciplinary palliative care team. I wonder whether the challenge for us as clinicians is to figure out how to effectively integrate primary palliative care with specialist care, so that both clinicians and patients get the support they need. A good model of integration would also help to avoid tensions around patient 'ownership' and duty of care between GPs and specialist services, which I think lies at the root of some of the concerns Brett highlighted from Geoff Mitchell's article, particularly those around a loss of primary palliative skills due to rampant 'specialisation'.

Meeting these challenges won't be easy, but with ongoing conversations like this, I for one feel more confident in our ability to overcome them.

Response from Prof Ian Maddocks Flinders University

BRETT MONTGOMERY HAS offered an honest, perceptive and thoughtful account of the realities of general practice, and of the difficulties of fitting an effective practice of palliative care into its wide-ranging responsibilities. He regrets this, and so should we all.

I was disappointed to receive this message from Western Australia. Accounts of the community palliative care offered there by particular GPs working with Silver Chain have been widely applauded and considered a model for other areas to emulate. Perhaps there is room for improvement everywhere.

I have no doubt that the best option for site of care for a dying patient is home.

Dr Montgomery outlines succinctly the problems for a GP in supporting that option: lack of knowledge, a disinclination to do home visits, and difficulty being available out-of-hours.

A further difficulty, one he does not mention in his article, is the care of seriously ill and dying patients in residential aged care facilities. Too often, partly through ineffective supervision by the GP, partly through nurse anxiety in the facility, a resident is shunted off unnecessarily to acute hospital care, and may die there, over-treated in an unfamiliar and uncomfortable setting.

Those difficulties need to be addressed. I submit that basic palliative care is not complex or onerous, and is 'everyone's business'. Perceived difficulties relate more to the lack of confidence that pervades young medical graduates, rather than any deficiencies in their knowledge base. Specialist palliative care can offer 24-hour phone advice, and this should be not with a distant stranger but from a local/regional service able to undertake its own home care visit if necessary. Home visits need to be much more part of undergraduate and postgraduate training, as well as better remunerated under Medicare. Out-of-hours difficulties are real, particularly for female graduates and other part-timers, but a GP's willingness to offer a 24-hour call number maintains both family confidence and continuity of care: the hallmark of good family practice. Safety issues are disturbing, and in some areas a security escort needs to be available for home visits out-of-hours.

Some of these difficulties would be diminished by a prescription that addresses Dr Montgomery's concerns and is both radical and prophetic. I have been arguing for the re-establishment of aged care facilities as community hubs. Each will include a general practice with a comprehensive team, including nurse practitioners enabled by training to maintain high standards of care in chronic disease, mental health, dementia and palliative care, in the clinic, the aged care facility, and across the local community.

A general practice in this setting will remain a full family practice with those

desirable characteristics outlined by Dr Montgomery and will offer outreach supervision of local home care. Alongside that, the hub will maintain facilities for healthy ageing: physical, with gym and pool; as well as mental and emotional, with group activities. It will undertake education, as a great centre for building confidence through experience; as well as research, through active university connections. It should invite and welcome specialist consultations in-house, and may also encourage specialist interest in cultivating better links and cooperation between hospital, aged care and home sites, so that unnecessary hospital transfers are minimised.

Is this no more than a vision? A vision is necessary for our future of growing numbers of elderly persons. And without a vision, the people perish.

Response from Prof Geoff Mitchell University of Queensland

WHAT IS THE best way of improving the skills of an inexperienced health provider? In his article, Brett Montgomery reflects on his unease at the thought of managing cancer symptoms at the end of life. His default position is an automatic referral to specialist palliative care. His reflection was prompted by a Canadian article which reported that short terms placed in palliative care were a mixed blessing for family medicine residents. On the one hand they enhanced communication skills, but on the other hand they reinforced the notion that skilled symptom control was a specialist level skill. This experience put people off trying to manage palliative care patients for themselves.

This is a real shame because I am certain that was not the intent. I am sure specialists want GPs to be engaged. However, particularly in urban areas where ready access to palliative care is the norm, and where there is frequently a direct line referral from oncology to palliative care, how does the GP get involved? (This is not nearly as

significant an issue in regional and rural areas where it is a given that palliative care is provided by the GP.) So there are two issues. The first is, how do we convey that most palliative care is doable by GPs? As in much of specialist practice, the patient load comprises the complex end of the spectrum, leaving the occasional practitioner exposed to a short term placement thinking that all palliative care is complex. Secondly, how does a system that channels patients direct from oncology to palliative care engage the patient's GP?

There is not enough room here to discuss these issues in full, but I raise a few points for consideration. First, there are three essentials to develop a skill – the practitioner needs to want to develop the skill; there need to be opportunities to practise it; and there needs to be support when people choose to have a go. Secondly, discomfort is related to inexperience, not incompetence. Experience comes from training and practise, so expect good GPs, particularly early in their careers to make occasional blunders and be ready to back them up. The role of specialists in encouraging the development of palliative care skills in GPs is critical. Expect the patient's GP to be involved, with the only question being to what extent? Anticipate that younger GPs in particular will be developing the skill and not get it right all the time. Encourage them to give it a go, and look at how your service supports those prepared to give it a go.

To the GPs: One thing that Brett's article raised was how we tend to distinguish between people with multimorbidity at the end of life – where the comfort level is greater – and cancer end of life. Everyone dies and in reality all GPs are engaged in end of life care, whether they realise it or not. Your challenge is to meet the patient's needs to the best of your ability, regardless of the cause of their illness. Give it a go, and don't be afraid to seek help when you need to.

We should all be thinking carefully about how best to provide coordinated, comprehensive end of life care to the best extent possible to all who need it – cancer or not. End of life care is everyone's business!

ANZSPM



DEAR EDITOR

I WISH I could have been part of Doug Bridge's ANZSPM Spirituality Workshop last September, particularly after reading the story, report and reflections in the November edition of this Newsletter.

I think most of us agree with the existence of spirit and the possibility of spiritual distress and suffering. If spirituality is the ground of our being, spiritual suffering could be seen as our alienation from that. With variations, many definitions observe the four aspects of spirituality to include relationship with self, others, environment and the transcendent. Such descriptions might allow acceptance by both the religious and atheist. The literature refers to many ways to measure these aspects of spirituality. For example, John Fisher developed SHALOM, a questionnaire that examines these four areas.¹ We applied this questionnaire to members of ANZSPM in 2007-8.² Many surveyed doctors didn't feel they had the capacity to help patients in the domains of spirit.

We know that patients have a range of unmet spiritual needs, and doctors might sometimes be best placed to identify and help. Similarly our own spiritual wellbeing is necessary if we

are to care for others and for ourselves, avoiding personal distress and injury in the process. The spiritual health of the patients we care for is our responsibility. So is our own. I wonder if they are two sides of the same coin? Ralph Waldo Emerson thought so: 'It is one of the most beautiful compensations of this life that no man can sincerely try to help another without helping himself.'

We need to be able to recognise and at least provide initial care of spiritual distress. Do we know what it looks like? Where are the boundaries between psychology and spirituality? How does a doctor approach the question of spiritual assessment of a patient? How would a model of spiritual care be different, for example, from existential psychotherapy? How might it be useful? What are the required skills for such care? What should we take on, and when and to whom should we make referrals? I don't think we have developed adequate answers to these questions.

These questions need to be asked of ourselves as well. Should a structured approach to self-care include a spiritual component? What advantage would that have for us? Should our College have something to say to trainees about spiritual care of others

and ourselves? The Royal College of Psychiatrists believes so.³

As a group we understand that we must be high-level communicators. Should we also aim for an overt training in talking about what life means, even if it is about to cease, or should we simply follow Osler, and simply 'minister to our patients through warm human contact'? I would enjoy a chance to talk more about these ideas.

Thanks once again, Doug.

Sincerely,
David Brumley

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Response from
Doug Bridge,
ANZSPM Spirituality
Workshop Facilitator

ONE OF THE immense joys of palliative medicine is the opportunity to develop deep friendships with colleagues. Although I rarely have an opportunity to meet with him, **David Brumley** is one such treasured colleague. Drawing on a lifetime of wisdom, David has concisely and beautifully asked all the right questions in the fourth and fifth paragraphs of his letter.

At its simplest, palliative medicine means accompanying the dying. That is terrifying. Eminent American existential psychotherapist Irvin Yalom has written a superb book called *Staring at the sun: overcoming the dread of death*. The title page bears this quote from Francois de la Rochefoucauld: 'Le soleil ni la mort ne se peuvent regarder en face' ('You cannot stare straight into the face of the sun or death'). The problem is, our patients are staring death in the face.

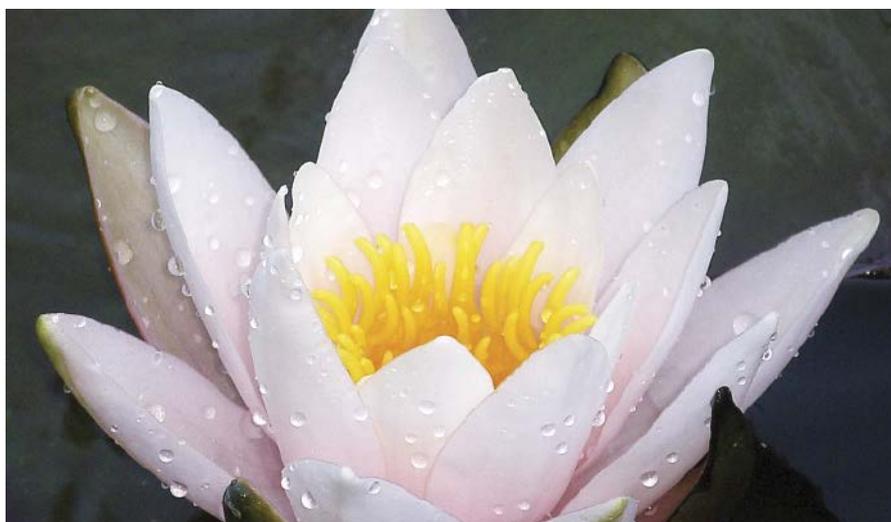


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A century ago, doctors tended bodies and priests cared for souls. With the decline of religious belief in Australia, many patients unthinkingly expect their doctors to fulfill a priestly role; to answer awesome questions like 'Why me?' How shall we respond to this daunting expectation? We have two choices, both valid. We can align ourselves with eminent UK professor of palliative medicine, **Sam Ahmedzai**, who identifies himself as a 'symptomologist', and devotes his great talent to relieving symptoms. He did valuable pioneering work on the use of transdermal fentanyl. He does not feel responsible for addressing psychosocial and spiritual problems. Or we can follow the North American pioneer of palliative medicine, **Balfour Mount** (who has himself stared into the face of death on several occasions) and view dying as an opportunity for integration and healing: 'It is possible to die healed.'

Palliative medicine in Australia has made wonderful progress in so many areas: symptom management, research, organisation of services, creating a mature specialist society (ANZSPM) and even contributing to the development of services in Asia. The last frontier is death itself. To stare at death we need all the wisdom we can glean from sacred texts, traditions, psychotherapy and philosophy.

Both ANZSPM and the RACP Chapter of Palliative Medicine agree that we should continue to develop training in spirituality. ANZSPM intends to progress discussions around the possibility of further one-day workshops for advanced trainees. These would essentially be repeats of the inaugural Melbourne workshop. They are intended to be specifically tailored to the needs of advanced trainees but also suitable for other health professionals. Even more ambitious is our wish to hold a two-day workshop to 'train the trainers'.

But there is one problem: who will train the trainers? We are blazing new trails, as palliative medicine has done so often. I hope David will join us and share his wisdom. At the end of two (relaxed and meditative) days, I hope we will have found some answers to his excellent questions.

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ANZSPM1607b

2016 Australian Palliative Link International Forum

Date: Wednesday, 22 June 2016 – 8:30am to 3:15pm
Location: The Royal Australasian College of Physicians
 Suite 7, Level 2, 257 Melbourne Street
 North Adelaide SA 5006

TOPICS AND SPEAKERS:

- **Global issues in palliative care:** Dr Andrew Davies, Clinical Director Palliative Care, Royal Surrey County Hospital, United Kingdom
- **Indian Cooperative Oncology Network:** Dr Rohit Joshi, Medical Oncologist, Director of Cancer Research and Clinical Trials, The Lyell McEwin Hospital Campus
- **Not just following my husband around – nursing perspectives from North India:** Jane MacKintosh, Clinical Nurse Consultant Palliative Care, Central Coast Local Health District, NSW
- **Updates on Assam:** Dr Niamh O'Connor, Palliative Care Physician, Territory Palliative Care
- **Hamrahi: Fellow Travellers, Fellow-ship: Learning from each other:** Assoc. Prof Odette Spruyt, Palliative Care Physician, Peter MacCallum Cancer Centre
- **Update on Palliative Care in Humanitarian Aid Settings (PCHAS) sub-committee of APLI:** Dr Brett Sutton, Public Health Registrar at Burnet Institute, seconded from Office of the Chief Health Officer, Victorian Department of Health and Human Services
- **Volunteering at Ganga Prem Hospice, Rishikesh, Uttarakhand, North India:** Dr Sally Williams, Senior Palliative Care Physician, Central Adelaide Palliative Care Service

To register, email Davinia Seah by 13 June 2016: info@apli.net.au
 APLI warmly welcomes members and non-members to this Forum
 Cost : \$25 per person with Indian buffet lunch provided

ANZSPM1618

JOURNAL CLUB

'Randomised double-blind trial of pregabalin versus placebo in conjunction with palliative radiotherapy for cancer-induced bone pain'

Authors: M Fallon, PJ Hoskin, LA Colvin, SM Fleetwood-Walker, D Adamson, A Byrne, GD Murray and BJA Laird.

Journal of Clinical Oncology
2015;doi:10.1200/
JCO.2015.63.8221

Study summary

By Celia Palmer
Palliative medicine registrar
Auckland City Hospital

WHEN STUDIES ARE randomised, double-blinded, and placebo-controlled, it is hard not to get excited as we are so bereft of such studies in palliative care. Pregabalin and gabapentin have been shown to reverse dorsal horn changes associated with painful osseous metastases in animal studies. Observational studies in human subjects have confirmed this finding. The investigators of this study wanted to find out whether pregabalin in conjunction with palliative radiotherapy for cancer-induced bone pain (CIBP) was better than radiotherapy alone.

The study was conducted between August 2008 and April 2012 across five cancer centres in the United Kingdom. Adults with a diagnosis of malignant solid tumours and radiological evidence of metastatic bone disease were eligible, but those with significant renal impairment (creatinine clearance < 60 mL/min) were excluded. Participants were randomised to receive either pregabalin or placebo, in conjunction with radiotherapy (either 8Gy in one fraction or 20Gy in five fractions, prescribed at the discretion of the patient's radiation oncologist).

The study was terminated early due to slow recruitment, after 233 (out of a target of 260) participants had been randomised.

The primary endpoint of the study was improvement in CIBP at the site of irradiation by four weeks. Improvement was defined as a reduction of ≥ 2 on an 11-point numerical rating scale, along with a stable or reduced opioid medication dose, compared to baseline. Forty-five patients in the pregabalin arm achieved the primary endpoint, compared to 47 in the placebo arm (38.8% versus 40.2%, odds ratio 1.07, 95% confidence interval 0.63 to 1.81, $p=0.816$). Thus pregabalin, when administered in conjunction with radiotherapy, was not significantly better than placebo at improving CIBP.

The first thing to note is the relatively low doses of pregabalin used in the study – between 150mg and 600mg a day. The effectiveness of pregabalin for the management of neuropathic pain has been investigated in nineteen double blind, placebo-controlled, multicentre studies with either twice a day or three times a day dosing.¹ In these studies there was a dose response relationship with more patients responding at 600mg a day. It is not clear therefore if the doses given were effective doses.

There did not appear to be adequate accounting for the confounder of the other medication patients were taking during the study. It is not clear whether some patients had their background opioid up titrated during the study.

The run-in phase into the double blind phase of the study was complicated. All patients had to have stable pain for five days, and yet experience a minimum amount of pain at the reference site. Some medications were continued during the study and others were not allowed. Exclusion criteria were wide including those

with mechanical or radicular back pain. These criteria make it difficult to know whether the study results are generalisable.

The follow-up period for a study including radiation therapy was short. The authors themselves state that onset of analgesia after palliative radiotherapy takes four to six weeks, yet their primary endpoint was set at just four weeks.

The outcome measure was the duration-adjusted average change from baseline in the daily worst pain at the reference site, as measured by an 11-point numeric rating scale. However, radiation therapy itself may temporarily increase inflammation and pain at the reference site, which in combination with the short follow-up period make assessment difficult.

As the authors state the confidence intervals were wide, leaving us less sure of the answer even if the above challenges could be answered. This study was not able to provide a definitive answer to the questions as to whether it is better to use pregabalin together with radiation therapy in malignant bone pain. It would be of interest to first explore the efficacy of pregabalin in bone pain, and secondly if palliative radiation therapy is a better option than optimising pain medication in CIBP.

References

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Invited expert commentary on the paper by Fallon, et al.

By Christine Sanderson
Calvary Health Care, Sydney

AS A PALLIATIVE care researcher, you get excited whenever you see a really well-done clinical trial trying to answer a tough clinical question in a real palliative care population. So – hats off to the research team on this project, which was clearly a difficult one. Many who were involved in the ketamine study would recognise the challenges, as well as some of the arguments in the accompanying editorial, which is also well worth reading.^{1,2} And here we have, like the ketamine study, a clearly negative result.

The clinical context is one of the more difficult pain problems that we deal with in palliative medicine and oncology – cancer induced bone pain (CIBP). The introduction section of the paper presents sobering figures on the effectiveness of radiotherapy in this context – with a meta-analysis showing that around a third of patients will not experience acceptable levels of analgesia from radiotherapy, and the onset of pain relief may not be for 4–6 weeks or longer, even though radiotherapy is the ‘gold standard’ treatment for this problem.

The authors summarise our current understanding of the pathophysiology of CIBP, which has features consistent with both neuropathic and inflammatory pain processes. Despite this, and the fact that pregabalin is generally indicated for neuropathic pain syndromes, there was no formal assessment for neuropathic pain as part of the trial assessment. This would have been very helpful in understanding the pain characteristics of the sample recruited.

The editorialists point out that many of those whose pain had significant neuropathic features may well have been excluded from the study because they were likely to have already been prescribed pregabalin or gabapentin – yet these are the very people who are most likely to benefit from the study medication. This is a potentially significant bias, which increases the chance of committing a type II error, and one that was acknowledged by the authors.

Certainly, the fact that 1970 patients needed to be screened in order to (nearly) achieve the sample size needed – which is nearly 9 screened for every participant recruited – gives an indication of the hard slog involved in this kind of research, and also suggests that the recruitment criteria may indeed have been a problem.

What else might have been missed by this study? Well, the participants may have continued to improve beyond the 4-week mark – although from the graphs this looks pretty unlikely. This was already a long study for a palliative care population, with a long run-in of up to 2 weeks to stabilise analgesia, before the primary endpoint was measured at 4 weeks. Whilst we know that radiotherapy benefits can continue to accrue beyond 4 weeks, the initial period before radiotherapy benefits kick in – when pain is most likely to be poorly controlled – is a highly clinically relevant target, as is the point at which pregabalin is likely to be of greatest value – if it is effective at all.

Were the patients actually given enough pregabalin? The paper states that patients were titrated to the maximum tolerated dose, which presumably means that further dose escalation was limited by drug side effects. The discontinuation rates in the treatment arm seem to indicate that pregabalin may have caused toxicity in some participants. However, the authors seem to dismiss this possibility, suggesting that the negative effects were not attributable to the drug.

These are difficult assessments to make in a trial, but at least the use of rigorous baseline assessments, careful management of all other analgesics, and the presence of the placebo arm, allow the investigators to draw their conclusions with some confidence.

Compare this with the complexity of daily clinical practice, where patients often have multiple pain sources and several treatment modalities all interacting with each other in real time, making it far harder to be clear about what is noise and what is signal, and what is causing changes – positive or negative – in patients’ symptoms.

So should pregabalin be prescribed for patients with CIBP? This paper suggests not, in which case reducing the unnecessary treatment burden, risk and cost to our patients makes good sense. However, the question about whether pregabalin may provide some benefit in patients whose CIBP manifests significant neuropathic features remains unanswered. But given the difficulty of the study needed to answer the question, it may remain unanswered for some time.

References

- 1 Hardy J, et al. Randomized, double-blind, placebo-controlled study to assess the efficacy and toxicity of subcutaneous ketamine in the management of cancer pain. *Journal of Clinical Oncology* 2012;30(29):3611-3617.
- 2 Raman S, et al. Does pregabalin still have a role in treating cancer-induced bone pain? *Journal of Clinical Oncology* 2016;34(6):524-526.

JOURNAL CLUB

'Outcomes of prognostic disclosure: associations with prognostic understanding, distress, and relationship with physician among patients with advanced cancer'

Authors: AC Enzinger, B Zhang, D Schrag and HG Prigerson.

Journal of Clinical Oncology
2015;33(32):3809-3816

Study summary

By Sarah Dunlop
Advanced Trainee
St John of God Hospital
Bunbury, Western Australia

Methods

This prospective multicentre American study aimed to address 5 questions:

- 1 Do patients with metastatic malignancies want to know their life expectancies?
- 2 Are they told their life expectancies by their physicians?
- 3 How does that prognosis translate into the patients' own perceptions of their life expectancy?
- 4 Does such disclosure influence the doctor-patient relationship?
- 5 Does the disclosure of prognosis influence patients' advanced care planning?

All of 590 patients enrolled between 2002–2008 had metastatic solid cancers that had progressed after at least one line of palliative chemotherapy. Trained interviewers conducted 45-minute interviews with participants in either English or Spanish, and also reviewed their medical records for key information. Patients were then followed up until their deaths or study closure at their particular treating site, after which survival was determined by National Death Index search. Mortality data was available for 83.2% of study participants.

A range of assessment tools was used to determine clinical, psychosocial and demographic factors. Patients were asked: 'Have the doctors talked with you about how much time you have left to live?' Those answering yes were asked to recall the estimate. Patients were also asked: 'If your doctor knew how long you had left to live, would you want him or her to tell you?' Prognostic understanding was determined by asking patients to estimate their own life expectancies and to evaluate their current health status. Further assessment tools were used to determine psychological distress and the patient-physician relationship. End-of-life care preferences were evaluated via a tool from the SUPPORT study and whether they had a do-not-resuscitate order, living will or had nominated a health care proxy (power of attorney for health care decisions).¹

Results

Only 17.6% of the patients studied reported having received a prognostic estimate from their physician. In this group the median life expectancy estimate communicated to them was 6 months. Overall, 71% said they would want their prognosis discussed.

A total of 299 participants were willing to estimate their own life expectancy. This represented 66.3% of those patients who reported having a discussion about prognosis with their physicians, compared to 47.3% of those who did not. Thus prognostic disclosure by physicians was associated with an increased willingness by patients to estimate their own life expectancy ($p < 0.001$).

The patients' self-estimate of their life expectancy was significantly shorter in the group who had prior prognostic disclosure than the non-disclosure group (median 12 months

versus 43 months, $p < 0.001$). After adjustment for age, race, religiousness and performance status, there was a reduction in estimated life expectancy of 17.2 months between the disclosure and non-disclosure groups. Patients in the disclosure group were also more likely to acknowledge that they were terminally ill (60.8% versus 28.7%, adjusted OR 3.21, 95% CI 2.99 to 5.15).

Median survival was 5.4 months (IQR 2.2 to 12.7 months) and survival did not differ significantly between the disclosure and non-disclosure groups (4.8 versus 5.8 months $p = 0.07$). Overall, 86.5% of patients overestimated their life expectancy compared with their actual survival, with 45.6% overestimating by more than two years, and 29% by more than five years. Life expectancies communicated by physicians closely mirrored actual survival. In contrast, patient self-estimates were overly optimistic, especially patients who had not reported prognostic disclosure by their physicians.

In the prognostic disclosure group, higher levels of sadness/depressed mood were reported via the McGill Quality of Life Questionnaire subscale. However, these results became non-significant after adjustment for age, sex, race, recruitment site, cancer type, and performance status ($p = 0.299$). Nor was there any association between prognostic disclosure and worried/anxious mood, major depression, generalised anxiety or patient-physician relationship.

The investigators hypothesised that those who perceived themselves to have a longer life expectancy would be disinclined towards advanced care planning, which was also borne out in the data. For every year increase in the patient's perceived life expectancy, there was a 2.5-fold decrease in the likelihood of having completed a do-not-resuscitate order (adjusted

OR 0.439 95%CI 0.296 to 0.630); a 2-fold decrease in the likelihood of having completed a living will and/or nominated a health care proxy (adjusted OR 0.722 95%CI 0.539 to 0.906); and a 1.5-fold increase in the likelihood of preferring life-prolonging measures over comfort-orientated care (adjusted OR 1.493 95%CI 1.091 to 1.939).

Conclusions

The study investigators noted that 71% of patients wanted to know their life expectancy but only 17.6% could recall this conversation. Where patients could recall the discussion of prognosis, their life expectancies were much more closely related to their actual prognosis and associated with increased propensity towards advance care planning, without negatively impacting on the patient-physician relationship. In their discussion, the authors compare their data to previous studies of oncologist-reported prognostication, where 43% of oncologists reported always discussing life expectancy with patients with advanced cancer, and acknowledged that recall bias, and the unwillingness of some patients to estimate their own life expectancies, were key limitations to the study.

References

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Invited expert commentary on the paper by Enzinger, et al.

By Adam Walczak
Senior Research Officer, CanTeen Australia
PhD Candidate, University of Sydney

INTUITIVELY, WE KNOW that prognostic discussions don't happen as often as they could. However, the disconnect between the desire of

71% of patients for a 'How long have I got, Doc?' discussion and the 17.6% who actually had one in Enzinger and colleagues' paper is quite stark.¹

So too is the finding that patients who had not had such a discussion estimated their life expectancy to be substantially longer, with longer life expectancy estimates also associated with a lower likelihood of do-not-resuscitate orders and an increased likelihood of preferring life-prolonging measures over comfort-oriented care. Importantly, prognostic disclosure was not associated with worse patient-physician relationship ratings, sadness, or anxiety in adjusted analyses.

The findings are largely in line with those of Jennifer Mack and colleagues, whose 2012 paper revealed that patients who had end-of-life discussions in the last 30 days of life were significantly less likely to receive aggressive measures including chemotherapy or acute care.² A recent finding that chemotherapy for end-stage cancer leads to poorer quality of death in people with good current performance status, and no improvements in those with lower initial performance status would seem to illustrate the validity of these less aggressive care choices.³

Coupled with evidence that early palliative care leads to longer survival,⁴⁻⁵ improved quality-of-life, reduced symptom burden and increased satisfaction with care,⁶ the question must be asked: 'Why, with all these indications of the chain of benefits of prognostic discussions, do they still not happen?'

Perhaps these discussions happen more often than patients recall? Enzinger and colleagues acknowledge the possibility that the vague terms used to discuss prognosis influence recall, or that patients may be in denial or too overwhelmed to recognise the discussion. Discrepancies in prognostic awareness and understanding have been identified between patients and clinicians in a number of studies with clinicians underestimating patients' need for information and overestimating

patients' understanding and awareness of their prognosis.⁷ Indeed, there are indications that the general public does not share the same understanding of terms such as advanced and terminal cancer as health professionals.⁸ It is thus possible that these conversations happen more frequently than recalled, but they are not remembered by patients due to the language used, the context of the discussions or reassurances that there is more that can be done, which may negate the message of incurability.

Knowing that the majority of patients want prognostic information may also not be enough to prompt clinicians to initiate a discussion and patients are often reluctant to ask for such information – leading to a collusion of silence that has been characterised as necessary for the preservation of hope.⁹⁻¹⁰ Jennifer Mack has challenged this and other prevailing assumptions that seem to drive clinicians' reluctance to discuss prognosis, and acknowledges the important reality that these discussions are hard for clinicians to have, that naturally one does not want to have them, but also that there is substantial benefit in having them.¹¹ Mack closes with the following challenge:

If the major barrier to prognosis communication that holds real credence is the pain physicians experience in these conversations, we should work toward supporting one another as physicians in these difficult tasks.

Enzinger and colleagues compellingly illustrate that patients have an unmet need for prognostic information and that this can have a substantial impact on end-of-life care. Ultimately however, it would seem unlikely that these findings will alter the status quo without greater attention being given to addressing the underlying skill, knowledge and confidence barriers that prevent clinicians and patients having meaningful discussions about prognosis.

The reference list for this article article appears on page 14 ►

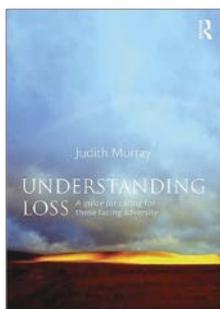
REVIEWS



BOOK REVIEWS

Understanding loss: a guide for caring for those facing adversity

By Judith Murray



London: Routledge, 2016

Judith Murray's book brings together much of the available knowledge on grief and loss and organises

it into a framework for systematically structuring the assessments and interventions that may help people experiencing loss. She argues for a 'psychology of loss' that recognises loss as an integral part of human life

and goes well beyond the common associations with bereavement to encompass all losses.

Part 1 of the book is introductory; it emphasises the experience of loss as normative and explores differing meanings and definitions. It also highlights the importance of respect, self-examination and self-knowledge for working in a caring role.

Part 2 comprises six chapters exploring what is known in this broad area. There is a thoroughly researched presentation of different models of understanding grief, backed by a comprehensive literature review. The experience of living with loss is presented from a number of perspectives, for example the nature of the loss, the individual's worldview and stage of development, and the ways in which their understanding is embedded in a spiritual or cultural context. Dr Murray emphasises significant issues, such as the fact that losses rarely exist alone and are integrated into the psychological

makeup of a person, providing examples in order to help the reader understand the importance of hearing and understanding the client's story from their point of view. She discusses the relationships between grief and loss and various psychiatric disorders and acknowledges human resilience and the difficulties that arise from pathologising either grief or the griever.

These insights lead her to develop ten 'Themes of Loss', in order to guide our understanding of the client and their situation, and provide a framework for 'enabling' or helping them through their difficulties. Part 3 of the book develops this framework with examples and diagrams, thus moving from theory to practice.

Understanding Loss is well worth reading as a summary of current knowledge and a synthesis of practice. What it adds is a practical approach to understanding the client and finding helpful approaches to care. The book illuminates the work of caring for a client regardless of the carer's specific clinical role, and it is certainly both academically precise and accessible. I recommend it.

Reviewed by Ofra Fried
Palliative care physician
Townsville Palliative Care Service

◀ Continued from page 13

Reference list for the invited expert commentary for the paper by Enzinger, et al.

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The Australian and New Zealand Society
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INVITED SPEAKERS:



Dr Pippa Hawley started the BC Cancer Agency's Pain and Symptom Management/ Palliative Care Program (PSMPC) in 1997. She works as medical leader of the Provincial PSMPC Program and the Vancouver team and is head of the Division of Palliative Care at the University of British Columbia teaching at all levels. She is also leading the drive for early integration of palliative care into oncology in BC and the creation of an academic palliative care network.



Dr David Kissane, MD is an academic psychiatrist, psycho-oncology researcher and author. His academic interests include group, couples and family psychotherapy trials, communications skills training, studies of existential distress and the ethics of end-of-life care. David is best known for his model of family therapy delivered to 'at risk' families during palliative care, which prevents complicated grief and depression in bereavement.

OTHER HIGHLIGHTS:

- **Trainee Day:** Katrina Anderson will cover the very important topic of fostering resilience and preventing burnout.
- **Media Workshop:** Hone or develop your skills dealing with the media with former print and broadcast journalist Marie Mills.
- **RACP Supervisors Workshop 3 (Work-based Learning and Assessment):** A must for budding supervisors.
- **GP Focus Day:** Delirium, Chronic pain... *and more*
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CONFERENCES & EVENTS

Conferences & Events Calendar

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www.eiseverywhere.com/?ehome/135123?eb=277681

Olympic Games 2016 Palliative Care

14–16 April 2016, Palermo, Italy • SAVE THE DATE
www.palliativegeneve.ch/wp-content/uploads/2015/09/Palermo-2016.pdf

Australian Grief and Bereavement Conference 2016: Bereavement in a Modern World: Global and Individual Perspectives

11–13 May 2016
conference.grief.org.au

● **ANZSPM Trainee Day (for ANZSPM Members) SAVE THE DATE**

20 May 2016, Sydney
 (Date and venue/city to be confirmed)
www.anzspm.org.au

8th World Congress of the World Institute of Pain

20–23 May 2016, New York, USA
<http://wip2016.kenes.com>

9th World Research Congress of the European Association for Palliative Care

9–11 June 2016, Dublin, Ireland
www.eapcnet.eu/research2016

The Oxford Advanced Pain and Symptom Management Courses 2016

16–17 June 2016, Newcastle, United Kingdom
<http://sobelleducation.org.uk/courses>

2016 Australasian Palliative Link International Forum

22 June 2016, RACP, Adelaide
 Email Davinia Seah by 13 June 2016:
info@apli.net.au

The Oxford Advanced Pain and Symptom Management Courses 2016

22–23 June 2016, Nottingham, United Kingdom
<http://sobelleducation.org.uk/courses>

● **ANZSPM Aotearoa Trainee Day**

1 July 2016 (full day), Totara Hospice, Auckland

● **ANZSPM Aotearoa 2016 (for ANZSPM Members)**

2–3 July 2016, Totara Hospice, Auckland
www.anzspm.org.au

The Oxford Advanced Pain and Symptom Management Courses 2016

7–8 July 2016, Oxford, United Kingdom
 14–15 July 2016, Oxford, United Kingdom
<http://sobelleducation.org.uk/courses>

Renal Supportive Care Symposium

29 July 2016, Sydney
 For further information:
 Elizabeth Josland or Alison Smyth (02) 91132854
elizabeth.josland@health.nsw.gov.au
alison.smyth@health.nsw.gov.au

7th International Conference on Patient and Family Centered Care

July/August 2016 (TBC)
www.ipfcc.org/events/conference.html

● **ANZSPM Conference 2016**

8–11 September 2016, Perth
www.anzspm.org.au/ANZSPM2016



The Australia and Asia Pacific Clinical Oncology Research Development (ACORD) Workshop – 2016

11–16 September 2016 (Applications now closed)
www.acord.org.au/index.asp

22nd Hospice NZ Palliative Care Conference

14–16 September 2016, Auckland
www.hospice.org.nz/conference-2016/conference-2016

Hospice Palliative Care Ontario HPCO 2016 Conference

29 September – 1 October 2016, Toronto, Canada
www.hpco.ca/conference/

PAL 2016 21st International Congress on Palliative Care

18–21 October 2016, Montreal, Canada
www.palliativecare.ca

23rd Annual Conference of the International Society for Quality of Life Research (ISOQOL)

19–22 October 2016, Copenhagen, Denmark
www.isoqol.org/2016conference

World Cancer Congress 2016

31 October – 3 November 2016 Paris, France
www.worldcancercongress.org/host-world-cancer-congress

EAPC 2017 15th World Congress of the European Association for Palliative Care

11–13 May 2017, Madrid, Spain
www.eapc-2017.org

IAGG 2017

23–27 July 2017 San Francisco, USA
www.iagg2017.org/en/

12th APHC – Asia Pacific Hospice Palliative Care Network

28–30 July 2017, Singapore
<http://aphn.org/asia-pacific-hospice-conference/>

ANZSPM 2016 publication timetable*

*Timetable is indicative and subject to change at ANZSPM's discretion

Publication	Material deadline	Position vacant ads must have applications closing no earlier than:	Publishing timeframe
E-Update April	22 April	13 May	End of April
E-Update May	24 May	14 June	End of May
E-Update June	23 June	14 July	End of June
ANZSPM Newsletter July	20 June	12 August	Mid-late July
E-Update August	24 August	14 September	End of August
E-Update September	23 September	14 October	End of September
E-Update October	24 October	14 November	End of October
ANZSPM Newsletter November	24 October	14 December	Mid-late November