ANZSPM Newsletter

Volume 19 Issue 1 April 2008

President's Report

The appointment of Karen Cooper as Executive Director (ED) of ANZSPM has already made a big difference to our governance and activity levels. Karen started on 28th January 08, working 3 days a week. She is based near Canberra, ACT. Her immediate focus has been to establish an office, develop a workplan, budget plan, and organise the formation of a working groups to undertake specific activities and respond to the immediate demands made on the Society, such as requests for endorsement. Having her representing ANZSPM on several College and other committees over the past two months has been a great assistance to Council and particularly to me as President, at this time of increasing role of the Specialty Society in College affairs. It is a time of steep learning and orientation for Karen however, the experience she gained while working as Senior Advisor/National Project Manager at Palliative Care Australia over recent years has prepared her well for this role.
A few of the activities initiated or developed by Karen over the last two months are:

- E-Update: ANZSPM receives a large volume of correspondence which we felt members would like to hear about. In these times of minute by minute communication, the quarterly newsletter was no longer the appropriate vehicle for such information demand. We have therefore started a monthly emailed communication with members, which will complement the quarterly newsletter. We realise many other such communiqués are received by our membership and were therefore hesitant to add to your daily influx of email. We would welcome your feedback (some of which has already been very positive) about the utility and interest of this contact. The E-Update will also provide an avenue for advertising position vacancies, activities of ANZSPM members, reports from ANZSPM representatives and ANZSPM activities that members may be interested in participating in. The quarterly newsletter will continue to provide an opportunity for more reflective or detailed discussion of issues and opinions.

- Increased Council activity: Council now has monthly one hour teleconferences. In addition, a regular teleconference has been set up between ED, President and NZ chair to discuss issues particular to the NZ branch. We will also be attending the NZ AGM in Wellington in May. Council is also in discussion with the Chapter of Palliative Medicine to more clearly define the roles of both organisations.

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- Development of advertising rates: we now have rates agreed by council for advertising in e-news, newsletter and website. There is also a package rate for all three. The rates are posted on the ANZSPM website or available from the ED office.

Planned activities:

Review of the services required by ANZSPM member: ANZSPM is establishing a working group to examine what these are and how we can best respond to these needs. This working group will have representation from both specialist and non specialist members to ensure that the needs of both groups will be considered.

Website upgrade: We have had problems with transferring our website hosting which has led to some of the lack of movement and loss of currency of the website. An upgrade has been in our sights for over 12 months, but finances and council time has made it difficult to commence. We are however convinced that this is an essential development for many reasons, including the opportunity it gives to provide resources for members and develop and maintain better contact between members. Discussion forums for trainees, development of special interest groups for members such as non-palliative care specialist members, identifying CPD activities for members to undertake by e-learning means, and perhaps producing resources if none already available, are just some of the activities possible with a

comprehensive upgrade. Over the next few months, we will be seeking bids for an upgrade and sourcing finances for this and will be looking to the membership for ideas and feedback.

Policy endorsement

Under our new governance, the Society is better able to respond to project tenders and policy documents such as the Thoracic Society's Cystic Fibrosis Standards of Care, Australia which we recently endorsed. We have discussed this with the Chapter of Palliative Medicine and developed a system of communication which we hope will allow for the widest consultation possible, including Chapter, specialist and non-specialist members of ANZSPM in the process and in what is usually a short time frame.

Working groups

ANZSPM is setting up 3 working groups in the following areas: constitution review, clinical indicators working group and MBS items working group. If people are interested in joining these, please let Karen know as soon as possible.

- Constitution Review: items such as the New Zealand representation on council, succession planning for council and trainee development as well as relationship to the Chapter of Palliative Medicine may need to be updated in the constitution.

- The Clinical Indicators working group will lead work in identifying 3 key clinical indicators that can be used national as measures of quality. These will be process indicators based on the work of Karl Lorenz (Lorenz KA, Rosenfeld K, Wegner N 2007 Quality indicators for palliative and end-of-life care in vulnerable elders. JAGS 55:S318-S326.) This work will complement, rather than compete with, the Australian national projects (PCOC, NSAP) currently underway. It is important that we show leadership in this area of quality development particularly for generalist colleagues or those working in other specialty areas, to improve the care of all patients receiving end of life care in whatever setting, not just those under our direct care.

- The working group to examine MBS items aims to challenge the initial terms of the 132/133 Medicare items which do not include home visits by physicians. We have had some difficulty capturing the number of home visits conducted as many palliative care doctors do not use the palliative care specific item numbers and so their activity is not well captured on the Medicare database. We encourage members to use these items rather than those generic to their base training. Palliative care physician home visits however are a relatively small component of palliative care medical practice nationally. The working party will lead the work in developing an application for new palliative care specific items that are based on the 132/133 items but that would include home visits and non-physician palliative care specialists consultations.

Conference

Finally, I would like to encourage you to attend the Darwin conference in September. Mark Boughey and his team have put together a great conference program supported by a great social program. Details are available on the conference website: http://www.willorganise.com.au/anzspm08 .Being in Darwin, the conference promises to raise our awareness of indigenous people's response to death and dying and also to bring us closer to neighbours in the Asia Pacific region. There are several major overseas conferences this year but if we are to grow as a Specialty Society we need to gather from time to time and share our experiences with each other. The ANZSPM conference has always provided a great opportunity for us to do just that. We are also planning the next conference to be part of the World Congress of Internal Medicine 2010 www.wcim2010.com.au. This means the 2008 conference will be the last opportunity to enjoy the renewal of ANZSPM friendships in a more intimate surrounds for some time. Hope to see you there.

New Zealand Branch Report

New Zealand and Australia continue to work together on implementing the new ANZSPM strategy developed last year. There are, as you would expect, some challenges in developing the society to accommodate two different countries with different health systems and different political systems but there are many advantages in sharing our knowledge and pooling our resources. Many items and information are of interest to all. This "across the ditch" collaboration has been well facilitated and supported by Odette and Karen - our new CEO.

This newsletter and the more recent monthly E-update is an opportunity for all ANZSPM members to report on what new initiatives are happening within the palliative medical community and share items of interest. This is our vehicle to communicate. I know the editor is always happy to have articles so please New Zealanders feel free to contribute your news by contacting Janet Hardy at editor@anzspm.org.au

The main focus of the NZ branch executive at the moment is our Annual NZ Branch conference which we advertised in the last newsletter in December. This is open to all ANZSPM members - New Zealanders and Australians. Although this is a smaller meeting than the Biennial ANZSPM meeting it is a

great opportunity for networking with colleagues. Rather than overseas speakers, the education sessions rely upon member participation (a formidable pool of knowledge and information!) and invited guests. There is one full education day on Saturday and a half day business meeting on Sunday. There are **no** registration costs which has to be a drawcard if you are a paid up member of ANZSPM. The only costs to you are your accommodation, flights/transport to the venue and some meals. Details are included in the registration form. Please contact me at joy.percy@midcentral.co.nz if you wish a registration form and draft program sending to you by email. Conference details are listed on the back page of this newsletter. Look forward to seeing you all there.

Joy Percy,

NZ Branch Chair

The NZ Palliative Care Working Party (PCWP)

PCWP was established in February 2007, having evolved from the PC subgroup of the Cancer Treatment Working Party recognising that PC is broader than just cancer. PCWP is an advisory group affiliated to the Ministry of Health and District Health Boards (DHBs), but has generated its own work programme to support the Palliative Care and Cancer Control Strategies.

The Working Party has representation from specialist palliative medicine and nursing, primary care, Maori, consumers, paediatric PC, Hospice NZ, education, residential care facilities, and management. Willie Landman represents (ANZSPM). It is a great group of people to work with.

Current work groups are addressing:

- Service Specifications for Specialist PC. This has been a major exercise, lead by Jonathan Adler and now awaiting final ratification. The 'service specs' introduce three new components to be expected - and paid for - from specialist services: education for generalists and support services, 24/7 telephone advice and support to generalist carers, and 'last days of life care'. The Ministry of Health has released $2m to support the introduction and initial implementation of these specifications.

- The PC and Cancer Nursing Education Group is chaired by Jackie Robinson, PC Nurse Practitioner. They have carried out a survey of their workforce and have enthusiastically drafted competencies which will be ready for discussion shortly.

- Palliative Medicine workforce. A stocktake of our "small and ageing" workforce was carried out. Anne O'Callaghan has written a discussion document and is leading the push to develop a national training programme rather than the current ad hoc system which usually requires a very committed trainee to cobble together their own training runs.

- A Syringe Driver Advisory group was convened in December to help to coordinate the transition from Graseby syringe drivers. The group includes representatives from Medsafe (regulatory agency) and DHBs. We have found the PCA/CPCRE documents extremely helpful as references - thanks!

- A medications work group has just been convened and will be chaired by pharmacist, Jane Vella-Brincat. They will consider a range of issues including access, equity, funding and appropriate use of medications in PC practice.

Anne MacLennan, Chair PCWP
Anne.MacLennan@ccdhb.org.nz

RMO attachments

RMO attachments as way of improving knowledge of palliative care and recruiting personnel.

The Palliative care community in Perth have been working together for 9 years to run an integrated community training position for Resident Medical Officers, (RMOs). In 1999, Sir Charles Gairdner Hospital(SCGH), one of Perth's large teaching instituitions, approached Silver Chain Hospice Care Service (SCHCS), asking if community placement terms could be created for RMOs. In response SCHCS together with the palliative care services of Royal Perth Hospital, SCGH and the in-patient palliative care units created a training programme and clinical attachment which has since 1999 placed 75 -80 RMOs. In 2007 the programme has been extended to a training registrar position which was accredited by the college in late 2007.

SCHCS is the only community palliative care provider in Perth. It has 8 multidisciplinary teams that cover the metropolitan area caring for 550-600 patients in their homes at any one time. The service has 1,500 – 1,600 deaths a year and a death at home rate of over 50%. The medical support for the teams is provided by GP's with special interest and training in Palliative Care. The doctor's role is to see every new admission within 48-72 hours of referral and provide anything from full care, shared care or nurse support. Doctors attend team meetings each week and provide 24 hour after-hours medical support. Each term, 2 RMOs are attached to 2 teams on a random or needs basis and take on the role of the doctors in admitting, assessing,

monitoring patients.

This is no ordinary RMO term. The first week is an orientation spent in an inpatient unit with tutorials and teaching. Practical knowledge particularly in relation to community work is combined with specific palliative care topics. Throughout the 10 week term they attend a weekly tutorial with a palliative care specialist and have strong one on one mentoring from the team's medical leader and nursing staff. They attend out patient clinics and ward rounds with the consultative services in the teaching hospitals.

By offering these community attachments we improve individual RMOs understanding of palliative care and symptom control. Importantly by placing RMOs in community teams we give them an understanding of what can be done in the home and how integration and good communication between hospitals, cancer services and home care services can improve health outcomes. In addition, we give junior doctors a personalised introduction to palliative care and hence increase the pool of future palliative care doctors as well as increasing the understanding hospital doctors of palliative care. The practical outcomes are that previous RMOS are advanced trainees, another a geriatrician, and one a palliative care specialist in Malaysia. Several others have joined community teams as GPs.

We are looking forward to presenting our education programme and formal evaluation of the programme at the ANZSPM conference in September.

Mary McNulty, Western Australia

ACTIQ® (Fentanyl Citrate) Registered Indication

ACTIQ® (fentanyl lozenge) was registered in Australia in November 2002.

The approved indication is "for the management of breakthrough cancer pain in patients with malignancies who are already receiving and tolerant to opioid therapy for their underlying persistent cancer pain."

Reimbursed Indication
The PBAC has recommended the listing of Actiq as a Section 85 Authority required benefit under the Palliative Care Section of the Pharmaceutical Benefits Scheme (PBS) for "the treatment of breakthrough pain in palliative care patients with cancer who are receiving opioids for their persistent cancer pain and where further escalation in the dose of morphine for breakthrough pain results in intolerable adverse effects".

The PBAC recommendation is as follows:
For Titration or Initial Supply*:
Max quantity: 3x3 = 9 units. Repeats: nil
For Maintenance or continuing supply:
-1st continuing supply (for up to 3 months)
Max quantity: 20 x 3 = 60 units. Repeats: 2
-2nd and subsequent continuing supply (for up to 3 months) where consultation with a palliative care specialist or service has occurred.
Max quantity: 20 x 3 = 60 units. Repeats: 2
-2nd and subsequent continuing supply (for up to one month) If there is no consultation with a palliative care specialist or service, and it's not convenient to get palliative care consultation, or where such consultation is not available, there is provision for the GP to write a continuing supply script for up to one month, but no repeats are allowed.
Max quantity: 20 x 3 = 60 units. Repeats: Nil

*There is no direct correlation between background opioid dose and the dose of Actiq required for pain relief. Therefore, the manufacturer recommends that clinicians start all patients on the lowest available dose (200mcg) and titrate as necessary to higher doses (400mcg, 600mcg). Thus the initial supply is of 3x 3 different dose strengths.

Palliative Care Outcomes Seminar

The presence of Irene Higginson and Karl Lorenz in Australia at the same time was too good an opportunity to miss. A Palliative Care Outcomes Seminar had to be arranged!

The Palliative Care Outcome Collaboration (PCOC) and the Department of Palliative Care (Calvary Mater, Newcastle) combined their considerable organizational skills and a one day seminar was duly conducted on Friday 12th October 2007.

After an impressive opening plea by Mr Stan Piperoglou Director of the Australian Government's Palliative Care section of the Department of Health and Ageing, we knew we had to work hard in this one day seminar

The day was then split into 4 parts.

1. First the theory – very thoroughly presented by Irene (giving us the UK perspective) and Karl (the US perspective). Karl persuaded us that we must grapple with outcome measurements and that there was much to be learned from large data sets already in existence particularly in the US Veteran Health arena. Subsets of outcome measures could be used to demonstrate quality care.

Irene emphasized the complexity of outcomes in a palliative care setting but suggested the need was to focus on the practical reality and be realistic about what is and isn't possible with outcomes measurement. A very useful concept was trying to measure the "shift" in attitudes of carers as well as patients when confronted by terminal illness individually or as a carer. Her well developed Palliative Outcome Scale (POS) although not perfect was a reasonable way to measure the impact of a palliative care team particularly in the short term. It produced evidence of a positive impact for patients and families.

2. The reality – 3 experienced and challenging Australian palliative care physicians provided high quality Australian cynicism about their experiences in trying to measure effectiveness. Janet Hardy took a scythe to the (Edmonton Symptom Assessment Schedule (ESAS), the Rotterdam QOL measure and the POS, but suggested we think about 'response times' to patient crises as something which could be used as a valid outcome measure. Odette Spruyt related her experiences in measuring pain outcomes. Paul Glare gave a beautiful dissertation on his unfulfilled experiences of good outcomes but did make some solid suggestions about the need to reflect on the difficult problems as a powerful measure to improve quality of care.

3. Getting down to business – Registrants were split into 2 groups to enable close range interrogation of Karl and Irene. The emotions began to be visible during these sessions – that's for sure.

4. Panel Interrogation – All presenters were then on a podium together and this proved to be a very useful question and answer session / sharing of experiences / being vulnerable etc.

The day was remarkable because we were saying it "as it was", and not pretending to be experts in palliative care outcomes. I think this has facilitated discussion into the future. It is likely we will have a more collaborative approach in our quest to measure outcomes in the future.

John Cavenagh, Newcastle

Trainee Report

The Palliative Care Australia conference held in Melbourne last August was a great time for trainees to renew old acquaintances and met a few new colleagues. On the Tuesday prior to the start of the conference there was a trainee education day organized by Dr Greg Crawford on the behalf of ANZSPM. High lights of the day included Rob Fasinger leading us, interactively, through end of life care. This was followed by Dr Kerrie Thomas discussing the Gold Standards Framework for Palliative Medicine in the UK. There was also an opportunity to pick the brains of newly qualified consultants and discuss the trials and tribulations of the transition from being a registrar to a consultant.

At the end of November 2007 the ANZSPM council had a face to face meeting in Melbourne. Trainee issues discussed included updating the ANZSPM website and creating a trainee page. This page could include previous projects for trainees to review to get an idea of how these should be formatted and presented, a list of research options and contacts and information on training sites. There was discussion regarding the next registrar training day in May and looking further ahead to the ANZSPM conference in September.

Adelaide will be the venue for the next registrar day. Toula Christou has been putting in lots of hard work to produce a great program to be held on a Friday so that attendees can chose to enjoy a weekend away if they want. It will be in May, but at the time of writing this article, the date is not finalised - I will contact you with the details by email. The second training day will be held on the Tuesday prior the ANZSPM conference in the last week of September, in the balmy heat of Darwin.

I look forward to seeing you all at one or both the trainee days this year.

Scott King, Melbourne

Hospice Africa Uganda

Four years ago I was able to have 6 months off from my work. as a part time palliative care clinician at the Mater Hospice. I thought I would use part of this time to visit a hospice in the "majority" world. St Christopher's hospice in London supports and has a directory of third world hospices. From the list I contacted Hospice Africa Uganda, (HAU), and Dr Anne Merriman who was happy to have me visit. Anne started the hospice in 1993 after carrying out a feasibility study as to where palliative care would be most appropriately based in Africa. During her time in Nigeria and Kenya, Anne was struck by the often painful deaths people were experiencing, particularly from HIV related illnesses. Up to 80% of these patients are reported to have significant pain (see BMJ 1997;314:23)

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Anne's model is home based without an inpatient hospice and is best suited for the needs of Africans. Uganda seemed the most suitable place for a variety of reasons: the government supported non government organisations without interference, the country was relatively peaceful (after the terrible slaughter by Idi Amin), the uniting language was English and Uganda is central geographically in Africa.

I had the privilege of working there for 1 month and returned again in December 2006 with my son David.

There are 3 hospices in Uganda - Kampala, Mbarara, and Hoima, each functioning as home based hospices with no inpatient service. Much of the work was with people suffering from AIDS related illnesses including cancer. Funding was from donations, particularly from the UK, where a registered charity was set up in 1993. They also have funding from large HIV funds in the US. Patients who can afford fees are asked to pay $5.00 per week towards their care, the total cost being $22.00/week.

Patients who are HIV positive comprise 30% to 60% of those treated by HAU depending on the geographic area. At present 30% to 50%of Ugandan AIDS patients are treated with anti retrovirals supplied free of charge by USAID.

Unfortunately one of the big UN donors, the Global Fund has withdrawn its funds from Uganda and Kenya because of government corruption and this has put great financial pressure on HAU. The proposed budget for 2008 is US$2million. There expenses include visit costs including vehicles, wages and petrol.

Medications are provided by the WHO and were in good supply for basic palliative care. Morphine is the only opioid available and Uganda is the first country in the world where nurses are registered to prescribe morphine. There is 1 doctor for every 11000 people on average and 1 for every 50 000 people in the country areas.

Education courses are a major emphasis of the hospice with many African countries sending nurses for education to take back to their own countries. Nurses from Camaroon, Ghana, Kenya, Malawi, Nigeria, South Africa, tanzania, Zambia, and Zimbabwe have completed courses.

War as well as disease especially AIDS has kept Africa poor and it was very encouraging for us to see the courage, energy, love and faith in the staff of the hospice and other support organisations. I will quote Noerine Kaleeba one of the pioneers in AIDS education which exemplifies the spirit of the Ugandans:-

"5 years ago in Uganda one man with a gun could walk through the door and take everything you had - just one man with one gun will make you lie down under the table and cover your face , while he takes everything. After you go through an experience like war, you come out a different person. Either you go down with the experience, or you rise - you are enhanced by the experience. So one of the things war has done for Ugandans is to produce a feeling of getting involved, a feeling of not wanting to suffer under the table."

In Uganda, I was impressed with the people's humility, their simple hearted nature and their desire to care for people in severe pain. Their faith and worship of their God was their source of strength. Both David and I were very grateful for their care of us. I loved working there and being a part of their team and their lives. My idea is to start Hospice Africa Australia to provide financial support to a country that is keen to care for its sick and suffering people particularly in regard to pain relief and hospice care. Any donations are transferred straight into the HAU bank account and used for hospice care.

Peter Coleman

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Journal Club

Challenges faced by palliative care physicians when caring for doctors with advanced cancer

Study Objective: To explore the experiences of palliative care physicians when caring for members of the medical profession with advanced incurable cancer

Study Design: Qualitative study, using semi-structured interviews, analysed using interpretative phenomenological analysis (IPA) for emergent themes

Population: 10 palliative care services physicians, selected from a hospice directory in the UK.

Outcomes: Major themes, with sub themes

Main results:

Control – blocking of psychosocial care, self-management and directing care

Organization of services – late access to palliative care services, lesser involvement of the multidisciplinary team in care,

exclusion of general practitioners

Behaviour of professionals – anxiety at initial consultation, transference, confidentiality issues, effect on own emotions

Limitations:

The interviews were conducted by a palliative care physician, and whilst this was described as bringing an awareness and understanding that will inform the analysis, it may also lead to inhibition in some of the interviewees. Responses are those as perceived by the doctor, rather than those of the patient. The study draws on previous experience which may be of different time scales, and may represent more complex and extreme cases. It only reflects the experience when the patient is actually referred to palliative care, and the experience may be different for doctor-patients that die, but are not referred to palliative care.

Conclusions: There are several core needs for all patients, and then doctor-patients represent a unique subgroup of patients with unique characteristics and needs. It is important to have a lead professional, and to be aware that doctor-patients are less likely to have their spiritual issues explored.

Commentary:

I chose this article because it reflects my experience of the challenging experiences I have had in looking after doctor-patients. Many of the themes resonate with that experience, especially the idea of control, and self referral, self medicating and self initiated investigations. I recognise the difficulties these patients have experienced in trying to let go of the intellectual approach to their illness and deal with the emotional and spiritual aspects of their care and approaching death. Ultimately we will all be doctor-patients and need to think about these issues for ourselves.

Noble SI, Nelson A, Finlay IG. Challenges faced by palliative care physicians when caring for doctors with advanced cancer. Palliative medicine. 2008 Jan;22(1):71-76.

Notices

MABEL – Improving your working life

MABEL (Medicine in Australia: Balancing Employment and Life) is a landmark new national longitudinal survey of doctors funded by the NHMRC and conducted by researchers at the University of Melbourne and Monash University. Without good evidence about doctors' own views, preferences, and work and family circumstances, health workforce policies are likely to be insensitive to the realities of medical practice and therefore less likely to be effective and maintain morale. MABEL is the first survey that will provide such rigorous evidence in Australia. GPs will be sent an invite letter or can register to take part in MABEL by going to www.mabel.org.au.

American Academy of Hospice and Palliative Medicine Introduces Patient Education Information on its Web site

The American Academy of Hospice and Palliative Medicine (AAHPM) features new patient education materials on hospice and palliative care on its Web site at www.aahpm.org. These articles were written by physicians, nurses, pharmacists and other healthcare providers and provide valuable information for patients facing serious or life-threatening conditions.

The Palliative Care Foundation

(PC Foundation) was established in 2007 to fund research and education programs in palliative care. Information about the types of scholarships and research grants available and how to apply for them is available on the website http://foundation.palliativecare.org.au/.

Conference Update

ANZSPM Conference (see page 8)

Themes: 'Innovations & aspirations', 24-27 September 2008 Darwin, NT

To register your interest in attending the conference see the conference website http://www.willorganise.com.au/anzspm08.

ANZSPM(NZ)/HPCNZ combined meeting

May 16th-18th,Brentwood Hotel,Wellington, NZ

This is the Annual meeting for ANZSPM NZ members. All ANZSPM members NZ and Australian are welcome. The meeting is combined with the HPCNZ (Hospital Palliative Care NZ group) representing all medical, nursing and allied health professionals who are working predominantly in hospital teams.

For further information and registration details, contact Joy Percy, ANZSPM NZ Branch Chair, at joy.percy@midcentraldhb.co.nz.

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Palliative Care Queensland Biennial Conference 2008.

"Creativity in Palliative Care". Sea World resort, Gold Coast

Sat May 24th. Contact: help@pallcareqld.com

16th International Conference of Indian association of Palliative Care

13-15 February, 2009 at Jawaharlal Nehru Auditorium, AIIMS, New Delhi INDIA

The objective of the conference is to "Update Knowledge in Palliative Care" and the theme of the conference is "freedom from pain". The World wide Palliative Care Alliance (WWPCA) is organizing a world wide summit in the same venue in Delhi on 11th -12th February, 2009. As interventional pain management is fast evolving into a subspecialty of pain medicine, we are planning to conduct one day cadaveric hands-on pre-conference workshop in Interventional Pain Management technique on 12th February, 2009. Please join in with your families, as they will have the opportunity to explore the most vibrant city of India. Delhi is a city of pleasant contradictions; a modern metropolis blossoming in the shadow of rich heritage.

Grief and Bereavement Workshops

The Australian Centre for Grief and Bereavement Education Program for 2008 will include seminars and workshops across Australia (except WA and NT).

Topics include: supporting the grieving child, strategies for working with grief and loss in children, providing support to those experiencing complicated and prolonged bereavement.

For more information see the Australian Centre for Grief and Bereavement website www.grief.org.au.

4th World Summit World Wide Palliative Care Alliance (WWPCA)

11-12 February 2009, New Delhi INDIA

17th International Congress on Palliative Care

September 23-26, 2008 Palais des Congrès in Montréal, Canada.

RACP Conference

May 11-15 2008, Adelaide, SA AUSTRALIA

World Congress of Internal Medicine

20-25 March 2010, Melbourne, Victoria AUSTRALIA
ANZSPM conference 2010 will be held concurrently.

2008 ANZSPM Conference Update

By the time you read this newsletter all members should have received an email and printed brochure announcing the opening of conference abstract submission and registration. Time to get planning and look towards Darwin at the end of September. If you have missed out or there are any delays the online version can be accessed at http://203.84.113.213/anzspm08/ or Google 2008 ANZSPM conference. You can also contact the conference organisers directly through their email address on the web site if you have any special needs or queries

For die hard AFL followers we will be making "special arrangements" for the AFL grand final on the Saturday after the conference if you are still in town. I hope that the proposed program will wet the appetite for the journey to Australia's Top End. We are hoping to provide an arts program at this years conference particularly orientated towards indigenous and non-indigenous Territorians. The social program will also showcase what Darwin has to offer and I note from the Sydney Morning Herald and Age supplement "Good Weekend" for the weekend of March 29th and 30th that sunset and dinner at the Mindil Beach Market is nominated as one of the worlds 20 food experiences one should have before you die...what an opportunity to tick this one off!

The success of any conference sits not only with the organisers and the invited speakers but with its participants and your enthusiasm to learn and participate that will energise your time at the conference. The organisers are keen. The invited speakers are all excited by the prospect of meeting in Darwin and sharing their stories. Now its up to you. The dry season is upon us but I'm hoping for a drought breaking flood of abstracts before the closing date of July 1st.

Best wishes
Mark Boughey, Darwin

Advertisement

Community Based REGISTRAR
Palliative Care
Joint position between Peter Mac, East Melbourne and Mercy Hospice, Sunshine (Predominantly based at Mercy Hospice)

The Peter MacCallum Cancer Centre is a comprehensive cancer centre providing medical, radiation and surgical oncology, and palliative care. The research activities of the Centre are well established and are a core activity informing clinical practice.

Mercy Hospice is a community resource covering City of Brimbank, City of Hobson's Bay, City of Maribyrnong, City of Melbourne, City of Moonee Valley, City of Wyndham and Shire of Melton.

A new Registrar position has been created under the Expanded Setting for Specialist Training Program for a Palliative Medicine specialty training position. The Registrar will be based at Peter MacCallum and work in the community, with the Mercy Western Palliative Care service. The aim of the position is to provide holistic palliative care to patients and their carers in the community, working within an expert community palliative care service. In addition, the position will include participating in two outpatient clinics and the research and academic program at Peter MacCallum.

There are two six-month positions. The first was available from February 2008 and the second in August 2008. We would be open to applications for more than six months given the existing vacancy. This position is included in the Registrar Rotation Program in Palliative Medicine and would be an excellent opportunity for advanced training in palliative medicine. It would suit a person with previous experience in areas such as palliative care, geriatric medicine, general practice or oncology. The position would be accredited for the Clinical Diploma of Palliative Medicine, College of Physicians.

Enquires to: Dr Odette Spruyt, Head Pain and Palliative Care on (03) 9656 1918 or email: Odette.Spruyt@petermac.org

Written applications (including the names and addresses of two referees) to: Dr Odette Spruyt, Head, Pain and Palliative Care, Peter MacCallum Cancer Centre, Locked Bag 1, A'Beckett Street, Melbourne, Vic 8006, phone: (03) 9656 1918 or email: Odette.Spruyt@petermac.org

Advertisement

Palliative Care Registrar – Training or non-training positions available - Brisbane.

You will be responsible, in consultation with Palliative Care Medical Specialists, for the delivery of medical palliative care to inpatients and outpatients referred to the Brisbane South Palliative Care Service. Also, you will be involved in established education and research programs and provide clinical support and set a professional example to junior clinical staff employed at QE11 Jubilee and Princess Alexandra Hospitals. The positions are accredited with the Royal Australian College of Physicians, Chapter of Palliative Medicine.

The Brisbane South Palliative Care Service has an interdisciplinary model of care and operates care across teaching hospitals, an acute palliative care unit and community-based environments including residential and aged care facilities. It has up to 2,000 admissions per year and provides excellent training opportunities.

A position is available commencing July 2008. For enquiries contact A/Prof. Liz Reymond 0412 302 135.

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Positions available

Palliative medicine physicians

Central Sydney Palliative Care Service
based at Royal Prince Alfred Hospital

Vacancies exists for experienced palliative medicine physicians to join this established palliative care service in Sydney's inner west.

The service is based at RPAH, the principal teaching hospital of the University of Sydney, and is part of the Sydney Cancer Centre, the busiest cancer centre in NSW.

The service provides consultations, inpatient care and outpatient clinics at three local hospitals and community outreach visits to a population of approximately 500,000 residents in surrounding suburbs.

The academic environment of RPAH provides excellent opportunities for teaching and research in all aspects of palliative care. Academic appointment in the Dept of Medicine, University of Sydney available if desired.

There are currently two vacancies amongst the six fulltime time positions in the service. They are supported by five accredited registrar posts which are part of the Sydney Institute of Palliative Medicine training network.

Applicants must have qualifications registerable by the NSW Medical Board and Fellowship of Chapter of Palliative Medicine RACP, or equivalent. Renumeration is in accord with NSW Salaried Medical Practitioners Award ($170,000-230,000 p.a.), with private practice option.

All enquiries will be treated in the strictest confidence. For more information contact:

Clin. Assoc. Prof. Paul Glare
Head, Palliative Care
Sydney Cancer Centre
Level 2, Gloucester House, RPAH
Missenden Rd, Camperdown, NSW 2050 Australia
Phone 02-9515-7755; fax: 02-9515-7464;
Email: paul@email.cs.nsw.gov.au

Sydney Cancer Centre
CURING, CARING, CREATING BREAKTHROUGHS

The University of Sydney
Australia

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Palliative Medicine Registrar

The Wesley Hospital, one of Australia's largest Private Hospitals, is seeking applications for a Palliative Medicine Registrar. The Hospital is a progressive facility winning many awards for quality inpatient care.

Applications are invited from registered Medical Practitioners for the position of Advanced Trainee in Palliative Medicine. The Wesley Hospital holds provisional accreditation for training by the Royal Australasian College of Physicians and this position is half time, shared in conjunction with the Palliative Care Service of the Royal Brisbane and Women's Hospital.

As an advanced trainee, potential applicants should hold a Fellowship in another medical specialty (e.g. FRACGP) or have completed part one of their RACP Fellowship.

Palliative Care Service – Our Palliative Care Service functions as a dedicated multidisciplinary team and provides hospital wide consultation for symptom control in advanced illness and holistic management of terminally ill patients. Considerable depth of exposure to the fields of medical and radiation oncology, and the full range of medical and surgical specialties can be expected.

The hospital has 17 beds dedicated to the provision of quality palliative care, and the service is unique in offering care within a very large private, acute care facility.

For further information please contact:

Dr Marguerite Robertson (Palliative Medicine) – (07) 3232 7355

How to apply:

Applications should include details of qualifications, previous experience and two nominated referees. Forward applications to:

A: Human Resources, PO BOX 499, Toowong QLD 4066

E: wesley.jobs@uchealth.com.au

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