ANZSPM

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Newsletter

Editorial

There has been considerable confusion over Medical Benefits Schedule (MBS) items for those doctors seeing patients in private or in the context of ROPP (Right of Private Patient) out-patient clinics. We have tried to clarify the current situation on page 6. It should be stressed however, that the purpose of the items is to increase the accessibility and affordability of consultant physician (CP) services for patients with multiple morbidities.

This is just one of many examples of issues where ANZSPM as your specialist body has an active role in negotiation and deliberation with governmental and other key organisations. Much of the work of ANZSPM is undertaken by a small number of dedicated palliative care doctors and may not be obvious to the majority of members. We therefore plan to highlight the work of the organisation as much as possible in future editions, if only to justify what is likely to be a substantial increase in membership fees over the next few years. ANZSPM is the only specialty body for doctors in Australia and New Zealand and must be recognised as such. Remember the link to an electronic version of the ANZSPM Strategic Plan 2007-2010. http://www.anzspm.org.au/StrategicPlan07.htm .

Merry Christmas.
Janet Hardy, Editor

President's Report

REINDEER REPORT - I recently came upon a children's poem with this title which succinctly reveals how life is getting harder for : "Driver: Christmas (F), Flightpaths: busier, Children: more And stay up later, Presents: heavier, Pay: frozen ..... Mission, in spite of all this, Accomplished!".

"Heavier", is how the load can feel for many of us at times. However, there are many positive signs to spur us on. We are a recognised specialty and have a well-developed curriculum and good structures for education and training upon which to build. We have increased support from national and, in many cases, State governments that has greatly spurred on research and opened opportunities for training. We are starting to speak a national language of standards and benchmarking. There are more jobs in palliative medicine in many States. ANZSPM is strengthening its role as your Specialty Society within the College of Physicians. And more.....

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A major factor with respect to easing the load of the ANZSPM council has been the appointment of a CEO. Karen Cooper has been working as Senior Advisor, PCA with responsibility for several major projects over recent years. She has a strong research and academic background, with a PhD in Physiology and extensive teaching experience including palliative care at ACU. Karen brings a very considered and thoughtful approach to project management and will greatly assist us in prioritising our strategic plan goals over the next 3 years. She plans to start work in February 2008. Her appointment will greatly enhance our ability to fulfil our role as your Specialty Society. In order to sustain this position, we will need to review our membership fees, which have remained at the current level for approximately 10 years. Members will be sent a survey in the New Year, asking about their expectations of the Society, their preferred means of communication with the Society, and to be advised on plans for fee changes.

The website has been the subject of much discussion in council lately. With the change to a new server, we have run into problems with the database access, which I hope will be resolved long before you receive this. However, we do need to overhaul the website, to make it more dynamic and relevant, a project for 2008. In relation to fees, we have also reviewed the policy of not charging for advertising on our website. Since most advertisements are for medical positions, advertised by an organisation, we feel it is prudent and reasonable to charge all for advertising and new costs will be listed on the ANZSPM website. A similar fee structure also exists for advertising in this newsletter.

Some national or recent initiatives of relevance to members include:

- PCA: National Standards Assessment Program (NSAP) meeting. This project aims to deliver a mechanism by which palliative care services can be assessed against the National Palliative Care Standards for continuous quality improvement. NSAP incorporates 3 stages. The first stage is self-assessment. The second stage is peer review assessment and the third stage is aligned with formal accreditation activity. The project will be lead by Prof. Sue Hansen. Given the ultimate goal of establishing an accreditation process, the opportunity for medical input must be grasped.

- MBS items. We recently received a concerned email about the new MBS items for the assessment of chronic and complex conditions and also about the new items numbers for geriatrics. We had a teleconference with Les Bolitho and Chapter representatives during our most recent Council meeting. One option discussed was whether to continue to go with the AACP line of lobbying for an increase in the Medicare benefit available for professional attendance items for consultant physicians and paediatricians. This recognises the increasing complexity of care required by many patients and aims to improve the level of Medicare benefits available to patients of Fellows of the RACP's Faculties and Chapters. We tend to think this is the better way to proceed, rather than to follow the path of the Geriatricians in lobbying for discipline specific items for consultations that have many parallels in other specialties and may be very conservative in their estimates of the need for these items.

- The Royal College of General Practice has been developing specific interest groups, some of which may evolve into Chapters within that College. A curriculum statement around a Chapter of Palliative Medicine in General Practice has been circulated to ANZSPM and the Chapter for comment. Council met with Dr Morton Rawlin, Director of Education Services and pointed out the sensitivity of the language. To some extent, this is imposed by the Royal College structure. We are interested in exploring opportunities to collaborate in areas such as CPD, concurrent conferences with RACGP, promotion of ANZSPM as a suitable "home" for GP's with a specific interest in Palliative Medicine and promotion of the Diploma of Palliative Medicine to GPs.

ANZSPM receives a large volume of correspondence and it is important that the membership are aware of some of the work that is done on your behalf.

- Chapter Palliative Medicine MOU –this has been put on hold for now, on the advice of the RACP

- Parkinsons Australia asked if our members would critique an online resource developed by them on end of life care. We have agreed to do so and you will be contacted by email with details

- Peter Coleman, a Palliative Care doctor in Newcastle, has asked ANZSPM to give its support for Hospice Africa Uganda in order to help HAU establish itself as a registered charity in Australia. We have agreed to do so.

- The Churchill Memorial Trust asked that we publicise their Fellowships which might be of interest to our members. Visit the Trust website for details www.churchilltrust.com.au

- RACP has asked the Specialty Societies to contribute to their February edition of RACP News, the theme of which will be the Specialty Societies.

- RACP are hosting the World Congress of Internal Medicine (WCIM) in Melbourne, March 2010 and we are invited to participate in this, with two options: hosting our conference concurrently and conjointly or meeting at the same time and venue but not sharing sessions or speakers. We are not yet decided about which option to follow, but plan to hold our meeting at the same time as WCIM as this is an excellent opportunity to showcase our work to physician colleagues.

- We have received three requests for assistance with research mailouts to ANZSPM members. You may have received one of these last month, two others are in the wings. We feel this is a useful service to our members conducting research and hope that the membership is happy to assist their fellows in receiving and responding to the studies.

Wishing you and those you love, the best of the Christmas season,

Odette Spruyt

New Zealand News

Not a lot has changed in the NZ national scene since my last report to the AGM but the good work on the following projects continues.

1. "Specialist Palliative Care Service Specifications for New Zealand". These have been written in draft and a national consultation process has finished. The specifications are expected to be completed later this year.

2. The establishment of "Palliative Care New Zealand" (PCNZ) - a national organisation for Palliative Care. The scoping document developed by the Palliative Care Advisory Committee has been approved in principle but funding is still to be secured.

3."Workforce Development and Planning". A project has been initiated to address Palliative Care Medicine Specialist Training, identifying the minimum number of training rotations required at present and those of the future.

I also wish to use this as an opportunity to advertise our NZ ANZSPM Meeting in May next year and encourage you to mark it in your diaries. This is a smaller meeting than the Biennial ANZSPM meeting and involves more member involvement rather than overseas speakers. However the collective knowledge of our members is worth harnessing and it also provides an opportunity for trainees, GP members and others new in the Palliative Care field to have an opportunity to present and share knowledge. There is one full education day on the Saturday and a half day business meeting on Sunday. Because of member input and some pharmaceutical sponsorship, there is at present no costs for the meeting itself. The only costs are accommodation, flights/transport to the venue and meals. We would love to see as many members as possible at next year's meeting, both our NZ members, who value this as a great networking opportunity, and our Australian colleagues who are also most welcome. See conference update for details. Wishing all a Happy Christmas and New Year

Joy Percy,

NZ Branch Chair

New ANZSPM Council Member

I am a newly appointed member of the ANZPM Council. I am a Palliative Care Physician based in Sydney and a Conjoint Senior Lecturer at The University of New South Wales. I am also a lawyer. Since becoming a Consultant in 2003 I have worked in Ireland and Australia. I have an interest in all aspects of Palliative Medicine, including its interface with the law, arts and the humanities.

I have been involved in the revamping of the Medical curricula at the University of NSW and the significant increase in the profile of Palliative Care teaching of undergraduate medical students. Over these years I have researched and published on pain management as a human right and, latterly, on Palliative Care and human rights. With the latter I am currently collaborating with colleagues in South Africa and the UK on a large project of publications and the creation of a curriculum on this topic. In addition I have written, published and broadcast narratives drawn from my clinical work.

As part of my work I am a great believer in the necessity of all Palliative Care health professionals reaching out to the wider community to describe, reassure and educate. To this end I regularly give talks to members of the public on all aspects of our work. Currently I am the Editor of the Newsletters of the NSW Palliative Medicine Society and the Australasian Palliative Link International (APLI).

Frank Brennan,

Sydney

Chapter Report - Joint Training

The RACP has recently gone through a rigorous Governance Review process that has culminated in the re-structuring of many of the College committees including the 2 committees within the Chapter of Palliative Medicine. The Chapter Committee has undergone minor changes only but the tasks of that committee are now more clearly defined, the President of ANZSMP is now a co-opted member and the Chapter Committee Chair now has the title of President.

The "Combined Palliative Medicine Education Committee" (CPMEC) is the new name for the amalgamated SAC Pall Med (Australia) and Chapter Education Committee and is tasked with overseeing the training of both streams of trainees under the one overarching curriculum. It is hoped that the SAC Pall Med (NZ) will soon be amalgamated with the CPMEC also.

The governance review stressed the importance of active engagement by Specialty Societies in the new Education/ Training committees of the College - hence the repeated reference to and involvement of ANZSPM, noticeable within the new CPMEC by-laws. The President of ANZSPM is an ex-officio member of the committee and along with the Chair of the CPMEC, the President of the Chapter and the Dean of the College will appoint fellows to the committee following calls for expressions of interest from the fellowship. Committee members will be allocated lead responsibility for the 6 different area of activity – accreditation, assessment, clinical educators, CPD, teaching and learning (incorporating curriculum and modules) and the Clinical Diploma. The transition to the new committee as outlined in the by-laws will be staged over the next 6-12 months so as not

to lose expertise and experience that currently exists. Peter Ravenscroft will be standing down as Chair of the CPMEC at the end of the year and a new Chair will be appointed. We are grateful for all his input and wisdom over a long period of involvement in Palliative Medicine education for the College

The Chapter will make available to interested fellows information regarding the tasks and responsibilities of the different committee portfolios in advance of calls for expressions of interest. I am happy to receive any questions or comments about the new structure or about potential interest in becoming involved or, if preferred, current committee members can be contacted via the Chapter secretariat.

Kate Grundy,

President, Australasian Chapter of Palliative Medicine

The Joint Therapeutics Committee

Palliative Care Australia (PCA) has reconstituted its Joint Therapeutics Committee (JTC). The JTC has representation from many key stakeholder organisations including PCA, Australia and New Zealand Society of Palliative Medicine (ANZSPM), Australian College of Rural and Remote Medicine (ACRRM), Palliative Care Nurses Australia (PCNA) and Clinical Oncological Society of Australia (COSA).The current representatives of ANZSPM are Phillip Good and Maria Pisasale. The purpose of the JTC is to represent networks of health professionals to identify inequities in and barriers to access of medicines used in palliative care and to recommend strategies to address these barriers. The JTC is linked with the Palliative Care Medicines Working Group (PCMWG) developed by the Australian Government Department of Health and Ageing. If you has an individual have an issue about inequities in access to palliative care medications that you would like to bring to the attention of this Committee please contact Phillip Good at Phillip.Good@mater.health.nsw.gov.au or Maria Pisasale at mpisasale@mercy.com.au.

Phillip Good,

Newcastle

Palliative Medicines Working Group

Doctors working in the area of palliative care are probably well aware of the improved availability of palliative medicines through the Pharmaceutical Benefits Scheme (PBS). BUT.... How often do we forget to use it? Do our non-palliative care colleagues know about the palliative care listings on the PBS? The uptake of the medicines has been encouraging since the first palliative care medicines were listed in 2004, but the absolute numbers of palliative care scripts written is still relatively small. Disseminating the message about improved medicines availability and quality use of those medicines, to clinicians, patients and carers is important. Clearly, palliative care specialists and GPs have an important part to play here. Palliative care doctors are frequently called on to provide education to fellow clinicians. This provides a great opportunity to influence the practice of peers as you speak to them about palliative care topics.

The Department of Health and Ageing may provide small communication grants to clinicians who take education to medical and other health practitioners in the community. For example, if you are planning to present at a conference, education session - perhaps in a rural area - funding may be available through the Department. The quid pro quo is that in your presentation, you will be asked to make specific mention of the Palliative care listings in the PBS and how they work. There are plenty of resources available to help do this. These can be found at the Caresearch website (ww.caresearch.com.au). go to the National Program tab and follow the link to Palliative Care Medicines Working Group (http://www.caresearch.com.au/home/Nationalprogram/Palliativecaremedicinesworkinggroup/tabid/253/Default.aspx).

Furthermore, if you are interested in presenting at a conference in 2008 with a focus on improving access to palliative medicines, the Department may assist with financial support. Please contact Donna Ridley (donna.ridley@health.gov.au) to discuss how you can help in spreading the palliative care medicines message.

Geoff Mitchell,

Palliative Medicines Working Group

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Quality Measures

Quality measurement is increasingly used as an important aspect of improving care. Essentially, in order to improve something, you have to know how you are currently performing, and tracking progress or failure over time provides important feedback on the next steps to take. There are various terms in use for this function including performance measurement or quality measurement. Generally, you can track either your outcomes or processes of care. Outcomes such as quality of life are the ultimate measures of our potential impact – however, many things other than the care we provide can affect outcomes, so we typically risk adjust for outcomes to try to make up for differences in outcomes not related to the care we provide (e.g., differences in pain outcomes related to types of diseases people have). Processes generally refer to things that we are directly responsible for as providers, and it is most useful to measure processes that are known to have a strong relationship to outcomes (e.g., appropriate opioid dosing and pain relief in cancer).

Both outcomes and processes may have a place in quality measurement in palliative care. When patients are very near the end of life, we don't know very much about what processes really matter, but we can still evaluate some important outcomes. On the other hand, processes are probably more important to measure earlier in the course of illness, when we have strong research evidence about some important things that clinicians should do. In addition, processes are important to measure because most clinicians would think that care was bad if the process of care was bad, even if things turned out fortuitously well for the patient. The Palliative Care Outcomes Collaborative (PCOC) is one of the first efforts globally to get routine, regular feedback from providers about clinical outcomes for their patients. As such, it's an important step that will help us learn a lot more over time about the best approach to obtaining information about our performance. Collecting either outcomes or process data is very time consuming, but outcomes are probably easier and therefore more feasible in many cases and a good place to start.

For measuring process, there are a variety of tools available for palliative care, and some examples of these tools have recently been published - Assessing Care of the Vulnerable Elders Quality Measures for Palliative and End of Life Care, Journal of the American Geriatrics Society October 2007. Because of the PCOC, Australia is playing a leading role in this important area.

Karl Lorenz,

Commonwealth Fund Packer Fellow

Book Review

Sandy Macleod, "The Psychiatry of Palliative Medicine. The Dying Mind",

Radcliffe Publishing Oxford, 2007.

Sometimes we find ourselves in situations were we don't know what is happening or how we will manage to cope. It is often not the physical problems our patients endure, but a patient with tremendous grief, relatives that we for some reason find it very difficult to relate to, or a patient that "upsets" the entire staff by his/her behaviour. To be in the fortunate position of meeting a psychiatrist who can explain to you what is going on and how to deal with it, is both a relief and an enrichment. Not today, and nowhere in the near future will there be an abundance of psychiatrists wanting to help out in palliative care. Sandy Macleod, being both an experienced psychiatrist and also a specialist in palliative medicine, with a rich personal practice in bedside palliation, is here to help us all with his extremely well written book, "The Psychiatry of Palliative Medicine, The Dying Mind". He has concentrated upon those clinical predicaments that frequently demand a pragmatic knowledge of psychiatry.

The book is just the right size, with chapters that covers themes such as adjustment disorders and anxiety, depression and delirium, and the transition from normal behaviour to minor or greater pathology, all in the setting of palliative care. Quoting from the chapter about depression: "Therapeutic moments to address grief issues occur in the shower, when changing dresses, chatting about life experiences or while tidying up the room". It is reassuring to read that many of the things we are doing intuitively are in fact correct. There is plenty of information about drugs and drug interactions. Here are sensible guidelines that will enable us to serve our patients and families more adequately.

In addition to the more "traditional psychiatric" themes, this book gives us insight into broader issues such as "psychiatry and pain", "psychological issues and dying", "euthanasia and psychiatry" and much more. This knowledge may help us recognise a potential "crisis" at an earlier time point, so that we can try to deal with it in a more appropriate way and learn when to seek help from a psychiatrist. There are specific chapters on diseases that primarily affect the brain such as brain tumours, cognitive dysfunction and dementia, and terminal neurological disorders. It emphasises the need to respect and show sympathy for those people who have to struggle with "loss of personhood". Reading these chapters

reminds us of the importance of palliative medicine at an earlier time point for many conditions.

I highly recommend this "guide to psychiatry in palliative medicine" for all healthcare professionals involved in palliative care, including consultants and senior nurses, as well as psychiatrists and all trainees in this field.

In the preface of this book Sandy Macleud humbly writes: "Hopefully this book may better inform medical and nursing practitioners about the psychiatry of relevance to the terminally ill". You have Sandy Macleod. Thank you!

Tone Nordoy

Tromso, Norway

MBS & Palliative Care

In the 2007-08 Budget, the Australian Government committed funding of $291.3million over four years for the introduction of two new Medicare Benefits Schedule (MBS) items, to support better provision of health services to patients with chronic and complex conditions. The purpose of the items was to increase the accessibility and affordability of consultant physician (CP) services for patients with multiple morbidities. Previously, consultant physicians were able to bill item numbers 110 (initial visit) and 116 for follow-up visits (see below). Two new items recognise the increasingly complex nature of clinical care required by the patients of consultant physicians and consequently the extended time that such consultations demand. They allow time for a comprehensive assessment of the patient and a treatment and management plan to be developed. The items have been developed in close consultation with the Australian Association of Consultant Physicians and the Australian Medical Association, and have been available for use from 1 November 2007. The higher fee will provide an incentive for CPs to practise in the non-procedural specialties, and to encourage new medical graduates to undertake training in these specialties.

Summary of the new items

Patients with at least two morbidities, are eligible for treatment under these items. All patients must be referred to the CP by their general practitioner (GP) or specialist.

Item 132 (initial patient assessment)

This must be of at least 45 minutes duration and can only be claimed once in a twelve month period by the same CP for each patient. The Medicare fee is $238.30.

The CP is required to conduct a comprehensive assessment of the patient, including a psychosocial history and medication review, formulate differential diagnoses; and develop a consultant physician treatment and management plan for the patient.

Item 133 (patient review)

This must be of at least 20 minutes duration and can only be claimed twice in a twelve month period by the same CP for each patient. The Medicare fee is $119.30.

The CP is required to review the patient's response to the initial treatment and management plan (including the original and differential diagnoses) and modify the patient's treatment and management plan where necessary.

Treatment & Management Plan

The development and modification of the treatment and management plan must include an opinion on diagnosis and risk assessment, treatment options and decisions and medication recommendations.

The problem

These item numbers apply only to CPs (those who hold a FRACP). They cannot be used by palliative medicine specialists (those who hold a FAChPM). Furthermore, they do not apply to home visits. The current item numbers for an initial and subsequent visits by a palliative medicine specialist (FRACP or FAChPM) are 3005 and 3010. The reimbursement for these item numbers is equivalent to that of 110 and 116 and is considerably less than that for 132 and 133.

ANZSPM will be taking an active role in the negotiations to address this perceived imbalance. In the meantime, all specialists are encouraged to use 3005 and 3010 rather than 110 and 116 to reflect the activity of the specialty.

In December 2006, the Chapter submitted two new item numbers to Medicare Benefits Branch. These were for conducting an interview with families/carers in consulting rooms or hospital without the patient being present and for case conferences for in-patients with a MDT of at least two other formal care providers of different disciplines. To date, there has been no decision on these submissions.

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ANZSPM would like to stress the importance of the Australian Association of Consultant Physicians (AACP) for future lobbying and to encourage members to join this Association. The AACP is the key advocacy body representing ALL Australian consultant physicians and paediatricians in economic and related workforce issues.

Further information

More detailed information on these items can be obtained by calling the Medicare Provider Hotline on 132 150. The item descriptors and explanatory notes can be downloaded from the MBS online website at: www.mbsonline.gov.au AACP website address is : www.aus-physicians.com.au/.

Syringe Driver Update

Graseby MS16a and MS26 syringe drivers have been the mainstay of subcutaneous infusion devices in Australia for many years. In October 2007, these devices were voluntarily withdrawn from the market as they are not compliant with the best practice standards for contemporary devices as set by the Therapeutic Goods Administration. While they can no longer be purchased, the manufacturer, Smith Medical, has a formal agreement to continue to provide maintenance and service support for a further five years. Palliative Care Australia (PCA) has worked with the Centre for Palliative Care Research and Education (CPCRE) in Queensland on a project to determine a process to provide useful information to health professionals about a replacement product. The process involved sector consultation around service providers' needs and the collection of information from companies marketing alternate devices.

Sector consultation

A list of 34 criteria thought to be important when considering alternate devices to the Graseby syringe drivers was developed by key stakeholders and grouped into categories. Health professionals from the palliative care and aged care sectors were invited to identify their top five criteria. PCA advertised this process through its e-bulletins and at the Australian Palliative Care Conference (APCC) in August 2007 and Aged and Community Services Australia national conference in September 2007.

The top criteria in each category, as rated by participants in the survey, are listed below.

-Safety : tamper resistant and tamper evident (through alarms, logs or physical measures)

-Simplicity : easy to set up and operate

-Cost : similar to the cost of current devices

-Functionality : lightweight and easily portable

-Transferability : suitable in different palliative care settings: hospital/home/RACF/rural

Marketing information

Companies currently supplying infusion devices within Australia were then asked to supply information as to how their product meets the criteria as listed above. This information will be published by PCA on its website and e-bulletins. The information supplied about these devices has been supplied by the companies marketing the devices and has not been tested or checked for accuracy by PCA or CPCRE. It is hoped that this information will support decision making by services when considering the purchase of alternate devices.

The role of PCA

Palliative Care Australia and the PCA Member Network will continue to highlight the impact of this change on our sector to both government and suppliers and to advocate that the following be taken into consideration when funding and planning for services; the cost of devices and disposables, the cost of training to health professionals, patients, their families and carers and the cost of improving safety through awareness and training across the many care settings. PCA will continue to monitor the market for alternate devices and inform the sector of any changes via its website and e-bulletin. PCA will be advocating on behalf of the sector for recognition of the impact of the changes and how they can best be addressed. It is recommended that services consult with other key organisations in their local area about the device that they are choosing to purchase. Using a similar device in an area would enable easy transfer of patients and residents between the acute sector and the community and lessen the required education and training of staff.

For further information, visit www.pallcare.org.au .

ANZSPM 2008 Conference

With the PCA conference over, work on the ANZSPM 2008 conference has been gaining momentum. It has been decided that the overall theme of the conference is looking at the "innovations & inspirations" that clinicians bring to their

workplace. Palliative care practitioners have often been seen as "can do" people who through necessity find and utilise creative and innovative ways to provide care. We want to capture and present the innovative ways in which doctors work in providing palliative care across the spectrum of services, institutions, locations and cultures, as well as looking at the ways in which we work and engage our colleague in other medical –service arenas. Through this we hope to hear from doctors and share what inspires us about our work and keeps people working in palliative care.

It is hoped that each day will provide a different focus: Day 1 "The clinical interface"- how we work with Oncology/ Haematology, Chronic disease, Aged care and Mental Health, Day 2 "Learning and wellbeing"- education, training, research and doctor wellbeing, Day 3 " Society & culture "- how we engage society-local to global, governments, cultures and with indigenous Australians. A 4th day will be dedicated to a trainees program

The conference organisers, Will Organise, who organised the Newcastle conference in 2006, are keeping things ticking over & on track. We are currently working on sponsorship arrangements as well as an exciting social program including the night markets at Mindel Beach and a balmy night outdoor conference dinner- all with a Territory flavour

We will be opening registrations and the call for abstract at the end of February 2008, closing at the end of May, 2008. Free crocodile repellent for those early bird registrations.

Mark Boughey,

Conference Committee Chair

Notices

NZ ANZSPM Meeting

Brentwood Hotel, Wellington, NZ May 17th and 18th 2008

Further details regarding registration can be obtained in the New Year from joy.percy@midcentral.co.nz

2nd Australian Lung Cancer Conference

Holiday Inn – Surfers Paradise, Queensland 21st – 24th August 2008

The ALCC and Exhibition will bring together leading medical, clinical and allied health professionals including internationally recognised renowned speakers in a program that will inspire participants to achieve even greater national and international recognition for Australia's excellence in the field of Lung Cancer.

For up to date information please visit the conference website**:** www.alcc.net.au .

The American Academy of Hospice and Palliative Medicine

(AAHPM), in collaboration with the Hospice and Palliative Nurses Association, will host its Annual Assembly January 30 - February 2, 2008, in Tampa, FL.www.aahpm.org.

RACP Conference

May 11-15 2008

Adelaide, South Australia, Australia

5th Research Forum of the EAPC

May 28-31 2008

Trondheim, Norway

2008 GP & PHC Research Conference: Health for All?

June 4-6 2008

Hobart, Tasmania, Australia

8th International Conference on Grief & Bereavement in Contemporary Society

July 15-18 2008

Melbourne, Victoria, Australia