

Editorial	1	"Mauve Pages"	4
President's Report	1	Changes to PBS	5
NZ Report	2	Book Review	5
CareSearch	2	PEPA 2	6
PCOC	3	Conference Update	8

Editorial

This is a good time to be in Palliative Care, not only because palliative medicine has finally been recognised as a specialty in its own right, but because of the many funding opportunities and exciting projects and initiatives that are around at present. Several such projects are highlighted in this edition of the newsletter.

The PEPA program for example, (see page 6) has been a great success. In PEPA 2, some 250 GPs have spent time with established palliative care services, to gain experience in the palliative approach to care. A number of these GPs have been placed within our unit and I have found the experience very rewarding. It has been especially interesting to meet doctors from rural areas who practice in an environment so different from my own and to hear of their experiences and problems in dealing with the terminally ill in remote communities. I see this program as a great opportunity to attract generalists into our specialty that is currently so understaffed. Our challenge is to leave these PEPA GPs so enthused that they elect to undertake formal training in palliative medicine.

The Palliative Care Medicines Working Group (PCMWG) is to be congratulated for all the work it has done in raising awareness of existing palliative care medicines listed on the PBS and improving access to medicines through the new framework for medicines on the PBS. Geoff Mitchell described this process in a previous edition of the newsletter (August 2005) and I have attempted to summarise some of the work done to date on page 6. I have also included the latest changes in the regulations controlling the prescription of narcotics for non-cancer pain (page 6).

The demands to measure clinical outcomes and key performance indicators are growing ever louder and seem to be coming at us from many different directions. Hence the concerns expressed by many about the extra work involved in the collection of data necessary for this. PCOC (page 4) is here to stay and is working closely with the Australian Institute of Health and Welfare (AIHW), the organisation responsible for the development of the national minimum data set. Their remit is to assist palliative care services to meet the national Palliative care standards.

CareSearch (page 3) continues to expand its role and function.

Finally, we draw your attention to the ANZSPM conference to be held in Newcastle in October this year - see our full page advert on the back page. The star cast of national and international speakers includes Dr Diane Meier, an expert in geriatric palliative care from the Mt Sinai School of Medicine in New York, and Sebastiano Mercadante from Italy. Maree Smith is the head of the Pain Research Group in the University of Queensland's School of Pharmacy, and Prof David Clark, a psychiatrist at the Monash Medical Centre. Topics covered in the plenary session cover the gamut from "the inner life of physicians and the care of the seriously ill" to "complex pain problems". There are refresher courses, workshops and palliative medicine trainee workshops before and after the main conference. The setting is

ANZSPM, PO BOX 2918, Cheltenham, Vic, 3192

Ph: 613 9585 1419, Fax: 613 9585 3785

Email: secretariat@anzspm.org.au

A/Prof Paul Glare President Email:
president@anzspm.org.au
 Assistant:
 Mrs Kathie M Thomas

Prof Janet Hardy Newsletter Editor Email:
editor@anzspm.org.au

fantastic for those who enjoy a brisk walk/run along the harbour side. See you there.

Janet Hardy, Editor

President's Report

In a momentous day shortly before last Christmas, the Minister for Health and Ageing, Tony Abbott, announced the recognition of palliative medicine (and pain medicine) as a speciality. This had been the dream of many when ANZSPM was founded in the early 1990's and the announcement was the final reward for the hard work by many on the ANZSPM Council over the past 10-15 years.

So what does it mean? In absolute terms it gives our specialty the status it deserves and hopefully will make palliative medicine more attractive to future doctors as a career path to consider. In practical terms, new items will be added to the General Medical Service Table of the Medicare Benefits Schedule for specialists or consultant who hold the relevant fellowships to access when providing related services to referred patients, "keeping this consistent with the current arrangements related to specialist services" according to the Medicare Benefits Branch of the Department of Health and Ageing. The new items will come into effect in May 2006.

In January, I represented ANZSPM at a meeting of the Medicare Benefits Consultative Committee where these matters were discussed. It was explained that the new palliative medicine and pain items can only be accessed by those medical practitioners who hold a Fellowship of the Australasian Chapter of Palliative Medicine, Royal Australasian College of Physicians, or Consultant Physicians who complete advanced Palliative Medicine training as part of their physician training and have thus completed equivalent training to the Fellowship, or the Faculty of Pain Medicine Australian and New Zealand College of Anaesthetists. There will be a legislative requirement for all eligible medical practitioners to use the items for their referred pain and palliative medicine patients. The pain and palliative medicine attendance and case conference items mirror those for consultant physicians. The new items will refer to a 'specialist and consultant physician practicing in the specialty of pain medicine or palliative medicine'. It was revealed that the Department originally intended to have joint pain and palliative medicine items, but subsequent discussions with Medicare Australia revealed that it would be best to have separate, but identical items for pain medicine and palliative medicine.

Thank you to all those who replied to the survey on clinical indicators (CIs). Discussion of Societies' progress on CIs at the RACP Special Societies meeting in February was held over to the September

meeting due to a lack of time on the agenda. More than 30 responses from around Australia and NZ were received to our survey, but only 12 respondents indicated that they were actually collecting CI at present. The commonest issue for CI's was pain although there was little uniformity amongst those using pain as a CI. The second commonest category of CI looked at response times but I believe these are more a performance indicator than a CI. An email will be sent out shortly to the membership, inviting you to be part of the CI working party, including to those respondents who said they would like to be in such a group.

In view of the success of the CI survey and the fundamental change to palliative medicine practice that speciality recognition is likely to bring, I would like to invite members to respond to the short survey enclosed with regard to their private practice. You can fax it back or else reply by email (email version to follow). Of course the responses will be treated as totally confidential and no identifying information is being requested (even though email and fax software preclude total anonymity!).

By now you should have received the registration brochure for the ANZSPM conference in Newcastle in October. Phillip Good and his team have put together an excellent program and I hope to see as many as possible of you there. Please put the dates – October 4-6 – in your diaries now.

Best wishes

Paul Glare, Sydney

Erratum: The editor apologises that Rohan Vora's authorship was not acknowledged at the end of his article "Palliative care in our Aging Society" in the last newsletter.

New Zealand News

The late start of the NZ school year in 2006 has prolonged the delusion of being on summer break. This year is likely to be of great significance for palliative medicine in New Zealand, with important initiatives gathering momentum.

As usual we start with some happy news-

What a great summer we are having-at least here in Auckland!

Congratulations to Kees Lodder from Auckland, who has gained his Fellowship of the Chapter of Palliative Medicine; and to Ian Gwynne-Robson for achieving the entry criteria to Chapter training, after a long, arduous and tortuous path. Well done to both of you.

Congratulations Australia for gaining specialist status in Palliative Medicine. This is the result of a lot of hard work done by a group of very dedicated colleagues, and I would like to make special mention of Will Cairns, who has provided focus and leadership for a long time. We have been fortunate to have had the benefits of their work, by attaining specialist status at an earlier date in New Zealand.

Not so happy news-

As a result of additional commitments up North, Warrick Jones has resigned from the ANZSPM New Zealand executive. He has been in charge of the chequebook for the past three years, and has also

represented ANZSPM on the National Cancer Treatment Working Party Palliative Care (NCTWP-PC) subgroup. Warrick has made a very valuable contribution to ANZSPM and we will sorely miss his cheerful spirit and wise counsel. Fortunately, as a result of his (relatively-speaking) youth, he will be able to make further valuable contributions in the future!

Andrew Wilson has kindly allowed himself to be coerced as a replacement for Warrick on the executive as well as taking on the treasurer role. Warrick has offered to continue to represent us on the NCTWP-PC subgroup until our annual meeting. I have offered to step into this role afterwards, if requested by the incoming executive.

New business -

We have decided that, following the very positive feedback last year, we will have another combined meeting with the Hospital Palliative Care New Zealand (HPCNZ) group this year, most likely at the end of July in Auckland. It is proposed that the meeting run from Friday to Sunday, to allow our GP members the opportunity to attend without having to take Friday off work. We will keep you informed re venues and dates. The executive has decided, because of the relatively healthy financial position of ANZSPM NZ, to bear the cost of the venue for this meeting. It has also been decided in principle, to keep the meeting free from industry involvement.

Our dedicated secretary, Joy Percy, has reminded me to put some pressure on you to keep your membership up (PAY YOUR SUBS!) and to encourage your colleagues to join ANZSPM. You will shortly be receiving a final reminder to pay your subscription and update your details for our database. The final date for receiving subscriptions and to be entered on the database is March 31st. After this only paid up members will be included in the database to receive newsletters and other ANZSPM information including newsletters from ANZSPM in Australia.

ANZSPM has an important role to play in the future as a representative body for all the medical professionals working in palliative care, and it can only be as representative and strong as its membership dictates!

Willie Landman, Auckland, NZ

Expanding CareSearch's Resources

CareSearch's role has gradually been increasing from collecting and making accessible Australia's missing palliative literature in CareSearch's literature databases to providing a broader range of resources and tools to support the palliative care community. The PubMed searches that were discussed in a previous newsletter are one example of these additional resources. There are however many other resources and facilities that are available through CareSearch. The new types of materials that are provided relate to patient care, research, education and training and service delivery. Materials held on the site are intended to complement rather than duplicate existing resources.

Patient care

Patient care is a new and developing section of the CareSearch

website focusing on clinical care and service delivery. It is building a series of topic pages that link practitioners with key documents and good quality resources that will assist in caring for patients and their families. Pages currently available include audit tools, palliative medications, indigenous palliative care, caregiver supports and aged care facilities. New topics are being developed and will be added over the next six months.

Undertaking research

CareSearch can support members of the palliative care community who are interested in undertaking research in a number of different ways. A new section of the website provides information and links to grants and tender opportunities. A Research Data Management system is available at no charge for Australian researchers and clinicians undertaking research in palliative care. This system enables the online design of data collection forms and questionnaires, allows for web-based and email-based form completion, enables data entry from multiple sites with a single co-ordinating site, provides for basic reporting of results and allows the export of data to other programs such as Excel, Access or SPSS. As well as being used for formal research studies, this system can be used to undertake quality improvement studies or carry out audits.

Educational opportunities

Early this year we introduced a conferences section to the website. We have expanded this to include links to both formal and short courses in palliative care held throughout Australia. We are hoping to be able to introduce some online educational resources in 2006.

Resources and Links

This section of the website has been expanded to include a project update section for the Knowledge Network project and the Palliative Medications Working Group. We have also included posters presented at palliative conferences in Australia and overseas.

Forums

The first forum has been introduced on the CareSearch website. This is an online discussion group or bulletin board. This open forum was specifically set up to support the introduction of the guidelines for a palliative approach in aged care facilities. The facility is available for other groups and can be run either as an open discussion group or as a private registered forum. This facility would be particularly useful for project or research groups who need a mechanism to exchange information or for special interest groups who want to be able to provide members with specific information.

Into the future

A number of other initiatives are also underway including the development of a searchable register of Australian palliative research projects. We are investigating the possibility of providing assessment tools and templates and forms for use by palliative services. We will also be continuing to add to the literature databases and have started to include citations and abstracts of palliative articles from Australian journals that are not indexed on any of the major electronic bibliographic databases. In this way we continue to grow the knowledge and evidence base for palliative care and build a community of clinicians, educators and researchers working in palliative care.

Jennifer Tieman, CareSearch Manager

Australian Palliative Care Outcomes Collaboration (PCOC)

PCOC is a voluntary quality network that will help the palliative care service sector improve practice and meet the "Standards for Providing Quality Palliative Care for all Australians". Essential to this is the requirement for robust, consistent data that provide a set of output and outcome measures for reporting on the performance of the service. It is this combination of data items that PCOC will develop and collect, on which it will report and provide analysis, and against which it will provide the environment that facilitates ongoing development and improvement consistent with best practice and the objectives of the quality and effectiveness goal of the *National Palliative Care Strategy*.

Aims of PCOC:

- To develop a national benchmarking system to improve clinical palliative care outcomes in both the public and private sectors.
- To produce information on the efficacy of interventions through the systematic collection of outcomes information in both the inpatient and ambulatory settings.
- To develop clinical and management information reports based on: the setting within which the service is provided; patient and carer information; the episode of care and the phase of care or stage of illness
- To provide comparative data to participating palliative care providers for benchmarking purposes.
- To provide and coordinate ongoing education and training in the use and definition of data items and other outcome measures for participating services.
- To provide annual reports that summarise the Australian data.
- To aid in the development of research proposals and undertake research as appropriate, to refine the selected outcome measures over time.

Why do we require PCOC?

PCOC is a quality initiative specifically designed to support continuous improvement in the quality and effectiveness of palliative care. PCOC will demonstrate both 'service' level outcomes and 'patient/carer' level outcomes across a range of settings nationally and in both the private and public sector. In addition, the data set that will result from PCOC provides the basis for extending the research and evaluation platform for palliative care practitioners.

Who can participate in PCOC?

Participation in PCOC is voluntary and is open to specialist palliative care services across Australia. PCOC will actively seek representation from the public and private health sectors, from rural and metropolitan areas, and from inpatient and ambulatory care based service settings.

What will PCOC achieve?

PCOC has been established to determine the data items required to measure continuous improvement in the quality and effectiveness of the services delivered.

Functions of PCOC

- Supporting services in joining PCOC: with training and education, IT training, establishment or modification
- Data bureau function: receiving and managing data from participating services, cleaning and validating the data, creating a database for analysis
- Analysis and reporting of data: developing data sub-sets for benchmarking and reporting and the provision of data and reports to feed back to participating services.
- Benchmarking service: facilitating continuous improvement arrangements such as round table workshops with participating services.
- Communications and marketing: developing and implementing a strategy to describes what PCOC is, how it works, and the benefits it provides.
- Reporting function: providing the results of research undertaken as well as describing and summarising data received.

What are the benefits of joining PCOC?

PCOC will provide:

- Standards report demonstrating compliance with key standards in *Standards for Providing Quality Palliative Care for all Australians*
- Six monthly reports to help monitor the performance of the agency
- A benchmarking process that will enable discussion of quality and effectiveness issues between like services
- Training in the outcomes measures used
- Support for SNAPshot where this is the software used. SNAPshot will be provided free of charge to those requiring it.

PCOC contact details:**Palliative Care Outcomes Collaboration**

C/o CHSD, Building 29,
University of Wollongong
Wollongong, NSW 2522

www.uow.edu.au/commerce/pcoc/about_pcoc.html

“Preparations that may be prescribed for patients receiving palliative care “the mauve pages”

The Australian Government has demonstrated its commitment to providing affordable access for palliative care medicines by

including palliative care medicines recommended for subsidy by the Pharmaceutical Benefits Advisory Committee (PBAC) in a new section in the PBS schedule. This new section in the schedule (the mauve pages) is intended to complement and be used together with the general listings section, where many drugs used in palliative care can be found.

For the purpose of prescribing under the Palliative Care Section, Palliative Care is not restricted to people with advanced cancer. A patient receiving palliative care is defined as: “a patient with an active, progressive, far-advanced disease for whom the prognosis is limited and the focus of care is quality of life”. This includes those with advanced organ failure such as heart disease or renal disease, or neurodegenerative conditions such as motor neurone disease, or fatal genetic conditions.

All palliative care listings are “Authority Required”. All prescribers can request an initial authority to provide a maximum of 4 months therapy for palliative care patients. Where a subsequent authority is requested for continuing treatment, the provision of repeats is subject to confirmation by the prescriber that a palliative care physician or service has been consulted regarding the care of the patient. Consultation can be as simple as a telephone conversation. That is a highly significant change, especially for doctors and their patients living outside cities, where access to palliative care specialists may be limited.

The drugs that have been available through the mauve pages for some time are: carmellose sodium (indication: dry mouth), hyoscine butylbromide (colicky pain), promethazine (nausea/vomiting), paracetamol in delayed release and suppository formulations (pain or fever), clonazepam (prevention of epilepsy) along with a number of laxatives.

The drugs approved for the December 2005 schedule were diazepam and oxazepam (anxiety), nitrazepam and temazepam (insomnia) plus a number of non steroidal anti-inflammatories (severe pain). More listings, often of drugs in formulations not previously available on the PBS will occur as the evidence required is gathered.

The indications for the use of a drug can be broader within the palliative care section. For example, clonazepam is listed for the treatment of epilepsy in the main part of the schedule. In the palliative care section, it is listed for the prevention of epilepsy, rather than for the treatment of epilepsy (including myoclonus). Similarly, non-steroidal agents are not restricted to “arthropathies with an inflammatory component or bone pain due to malignant disease” but can be used “where severe pain is a problem”.

In addition, the restriction on repeated prescribing of benzodiazepines has been eased. Previously, repeats of benzodiazepines could only be prescribed for nursing home patients who had been shown to be dependent – that is, who had failed a trial of withdrawal. Under the new listing, doctors can write multiple prescriptions for benzodiazepines for people needing palliative care and do not have to prove addiction.

Changes relating to the prescription of opioids are listed in the following article.

The Palliative Care Medicines Working Group, with representation from clinical disciplines, government, consumers and the pharmaceutical industry, continues to work with the Therapeutic Goods Administration (TGA), the Pharmaceutical Benefits Advisory Committee (PBAC) and

sponsors (generally pharmaceutical companies) to support the listing of priority palliative care medicines on the PBS. This is a slow and often difficult process as illustrated by Geoff Mitchell in his article in the August 2005 edition of this newsletter. We as clinicians can support their endeavours by:

- Raising the awareness within the primary health care workforce of existing palliative care medicines listed on the PBS and
- By using the authority system and not the general benefits system when a drug is available in both lists, but is to be used for palliative indications.

Janet Hardy, Brisbane

Key points:

- Some common palliative care medications are now available in different forms.
- Some common palliative care medications are now available for different indications.
- Most palliative care medications can now be prescribed for longer periods.

Some restrictions on opioids and benzodiazepines have been removed.



different criteria of the restriction such that:

- The initial PBS authority request applies when the total duration of narcotic analgesic treatment is less than 12 months.
- Should the treatment exceed 12 months, a subsequent application is required to extend the supply beyond 12 months; it is this application that requires the details of a pain management review conducted within the preceding 3 months.

Then, if treatment continues and further supply is needed, this subsequent application does not require a pain management review; a review only needs to be demonstrated the first time use will exceed 12 months. Nonetheless, applications for treatment that extends beyond 12 months can only be approved if a PBS authority for narcotic analgesic treatment beyond 12 months was previously approved for that patient after a review of the management was provided by another practitioner (possibly another doctor from the same practice).

Note: the above does NOT apply to cancer pain.

National Prescribing Service. PBS narcotic authority recommended. NPS RADAR August 2005.

www.npsradar.org.au/site.php?page=1&content=/npsradar/content/latestnews.html#aug05 (accessed 15 Nov 2005).

Changes to Narcotic Analgesic Prescribing on PBS in April 2006

Changes to PBS prescribing of narcotic analgesics were introduced in April 2005 and relate to obtaining a PBS authority to prescribe increased quantities or repeats of hydromorphone, methadone, morphine or oxycodone for severe disabling pain. The changes were outlined in the 'In Brief' section of the August 2005 issue of NPS RADAR1 and will also apply to the 1 December listing of buprenorphine patches for severe disabling pain.

From 1 April 2006, the criterion that allowed patients whose narcotics were started in hospital before April 2005 to be prescribed increased quantities or repeats under PBS authority will be deleted. This means that prescribers will need to ensure that a pain management review has been conducted by a second medical practitioner to confirm continued clinical need and avoid potential interruption to the patient's continuing PBS supply of narcotic analgesic. The pain management review needs to have been conducted within the 3 months preceding the date of the PBS authority request.

The criterion relating to initiation of narcotic treatment in a hospital is the only criterion being removed; all other changes introduced in April 2005 remain. However, Medicare Australia (formerly the Health Insurance Commission) advise that experience since the changes were introduced has revealed some confusion among prescribers applying for PBS authorities for increased quantities or repeats of narcotic analgesics.

It is intended that the PBS authority requests progress through the

Book Review

**"Opioids in Cancer Pain" – edited by Mellar Davis, Paul Glare and Janet Hardy
Oxford University Press, 2005**

This is a book about opioids rather than cancer pain management and in the introduction there is no apology for focussing on this specific aspect of cancer pain. In the introduction by Mellar Davis he quotes "A good book should not be like bronzed shoes that once finished are placed on the shelf to be admired as something past, never to be worn again." I think that owners of this text will not be at risk of treating this book in the same manner. It is a text that is likely to become well used and "thumbed". This text is a useful addition to the library on cancer pain management.

The editors are the major contributors to this volume. Mellar Davis is the Director of Research at the Harry R Horovitz Center for Palliative Medicine in Cleveland, Ohio USA; Paul Glare and Janet Hardy are well-known to ANZPM members. Paul is the Head of the Department of Palliative Care at Royal Prince Alfred Hospital, Sydney and Janet is the Director of Palliative Care at Mater Health Services, South Brisbane, Queensland. The other contributors are Kenneth Jackson, Assistant Professor in Pharmacy in Texas Technical University Health Sciences Center, Texas; Tony Hall, Assistant Director of Pharmacy, Mater Health Services, South Brisbane; and Gavril Pasternak, Attending Neurologist and Head of the Laboratory of Molecular Neuropharmacology, Memorial Sloan-Kettering Cancer Center, New York.

After a succinct introduction setting the focus of this text, the initial chapter is on opioid receptors. This chapter contains a great deal of detail and is a useful point of recurring reference and "sets the stage". Then follows a chapter on Pharmacokinetics and then chapters devoted to specific opioids. These chapters are relatively short, accessible and clinically relevant. Not all opioids are covered,

but certainly the major ones that are available in the western world. Then follows a series of chapters dealing with topics such as the WHO ladder, opioid rotation, equi-analgesia and opioid dosing strategies. The text is completed with chapters on patient controlled analgesia, spinal opioids in cancer pain and opioid resistant pain.

Levels of evidence are discussed openly and there is use of Clinical Guidelines and Case Reports to illustrate specific issues and dilemmas. I particularly liked the very last paragraphs of this text on "opioid irrelevant pain". This is a text of opioids in cancer pain, however it would be inappropriate not to mention, as is done in the introduction, the existence of non-pharmacological interventions for pain and in the conclusion the impact of social, psychological and spiritual factors on pain and suffering. "The pervasiveness of the biomedical model accounts for much of the defects in contemporary health care and the dissatisfaction amongst those patients who truly suffer".

This compact, easily accessible text is an invaluable resource for doctors practicing advanced Palliative Care, for Pharmacists, Pain Specialists and Oncologists. It is part of a series of other texts published by Oxford University Press; The Syringe Driver; The Oxford Handbook of Palliative Care; and Cancer Clinical Pharmacology. This book brings together information on opioid receptors and opioid pharmacokinetics, with individual drugs tackled in a manner. This text is available from reputable medical text suppliers and on line it is possible to purchase it for \$A170.

Greg Crawford, Adelaide

Conflict of interest: Janet Hardy (editor ANZSPM newsletter) and Paul Glare (President of ANZSPM) are both editors of this text. They had no input to this review and have not changed its context in any way.

PEPA 2

The Program of Experience in the Palliative Approach (PEPA) is an initiative of the Australian Government, Department of Health and Ageing, National Palliative Care Program. PEPA aims to improve the quality, availability and access to palliative care for people who are dying, and their families. To achieve this aim, PEPA provides workforce placements and structured learning experiences to develop the capacity of health care practitioners to deliver a palliative care approach.

PEPA commenced in 2003 and was offered to over 500 nurses and allied health practitioners from primary health settings (PEPA 1). In 2005, PEPA was expanded to include placements for General Practitioners, rural and remote medical staff and specialist palliative care staff (PEPA 2). In the coming months, nearly 250 General Practitioners and medical staff from rural and remote settings will complete placements at specialist palliative care services as a part of PEPA 2. In fact, PEPA has been so popular, it has been oversubscribed and health care staff have been unable to be placed.

Evaluation of PEPA is in progress, using a framework developed for the Caring Communities Program. The evaluation includes survey of all participants, their employers and host site personnel. Interviews are also being conducted with a selected group of PEPA stakeholders to obtain more in-depth information.

Some of the important issues that have emerged to date:

Many participants are reporting increased confidence to care for people with life limiting illness in their own workplaces related to discussing end of life issues, implementing interventions and reassessing the needs of their patients.

PEPA has provided an opportunity for primary health care providers to develop links with palliative care and other services and disciplines to assist in the care of patients.

Employers support PEPA as a strategy to increase their organisation's capacity to provide for people with life limiting illness.

Overall, the responses from participants and host sites indicate that PEPA develops knowledge and skills in the palliative approach and enhances the communication between settings.

The following responses from medical practitioners who have undertaken a PEPA placement provides examples of outcomes of the Program.

"Have more confidently transferred patient from oral narcotics to subcutaneous narcotics. Have been able to rationalise medications in dying elderly patients. Have assisted patients to go home initially before death in hospital."

"It has made me more confident and made me more aware of other issues,..... able to discuss dying with patients where previously I found that very hard."

Listed below are some examples of initiatives implemented by General Practitioners following their PEPA placement.

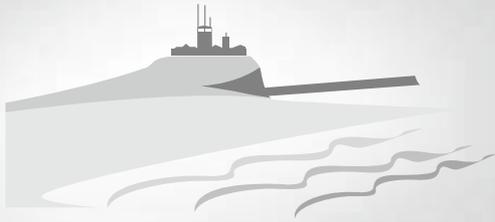
"Practice clinical meetings. I have been able to use the knowledge gained as part of our regular care discussion. Together with the resource material brought from the palliative care service I believe care of our patients is more informed and a better standard."

"Regular fortnightly discussions with palliative care nurse and other medical colleagues on managing as patients. Discussions with medical colleagues regarding pain management options; placement options. Feeling much more comfortable about openly discussing issues with this group of patients and their family."

The contribution from palliative care services in all States and Territories has been an integral part of PEPA and has been greatly appreciated.

Linda Barrett, National Co-ordinator

Plus:
Erratum (page 2)
Conflict of Interest (page 7)
Conference flyer and updates (page 8)



Australian and New Zealand
Society of Palliative Medicine
Newcastle, NSW
4-6 October 2006

ANZ } SPM

AUSTRALIAN
AND
NEW ZEALAND
SOCIETY OF
PALLIATIVE
MEDICINE
CONFERENCE
4 – 6 October
2006
NEWCASTLE
NSW

DESTINATION

Newcastle is Australia's 6th largest city, and one of its oldest. It has a fast growing reputation as a conference destination as it offers a unique blend of big city facilities and country town friendliness. It is the capital of the Hunter Region and the most popular tourist destination outside of Sydney in NSW.

INVITED SPEAKERS

Diane E. Meier, MD

Director, Lilian and Benjamin Hertzberg Palliative Care Institute Director, Center to Advance Palliative Care Catherine Gaisman Professor of Medical Ethics Professor Departments of Geriatrics and Medicine Mount Sinai School of Medicine

Sebastiano Mercadante MD

Chief of Anaesthesia & Intensive Care Unit, Pain Relief & Palliative Care Unit, La Maddalena Clinic for Cancer, Palermo, Italy

Maree Smith

Professor and Head of the Pain Research Group, School of Pharmacy, University of Queensland

Linda Kristjanson

RN, BN, MN, PhD. Professor of Palliative Care Nursing at Edith Cowan University

These will join local speakers to give talks on diverse and stimulating topics. The first major topic area that will be covered relates to pain (specifically complex pain situations, opioid poorly responsive pain, neuropathic pain, palliative treatment of bowel obstructions, opioid receptor updates, combining opioids, new opioid preparations). Another major topic will be looking at practical ways of dealing with spiritual distress. As well we hope to look at palliative care in non-malignant illnesses – where the boundaries lie.

THE MEETING

The Australia and New Zealand Society of Palliative Medicine holds a major conference every two years. The meeting is the major conference for medical practitioners working in Palliative Medicine in Australia and New Zealand and also for parts of South-East Asia. As well the conference has an emphasis on General Practitioner education, and as such expects a large local contingent of general practitioners to attend.

If you would like to be kept up to date with the progress of this conference, please either contact the secretariat on the below details, or register your details online at www.willorganise.com.au/anzspm.

Secretariat: PO Box 180, Morisset NSW 2264

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

Email: anzspm@willorganise.com.au

ANZ } SPM

Conference Updates

<p>RACP Congress, Adult Medicine Meeting May 9 – 10. 2006 Cairns Convention Centre, Cairns (includes Palliative Care Symposium, Wed 10th May) http://congress.racp.edu.au</p>	<p>Research into Practice Joint meeting of CPCRE and PCQ Brisbane June 2 – 3, 2006 Education and Conference Centre, Royal Brisbane and Women’s Hospital. www.pallcareqld.com</p>
<p>The Inaugural Australian Lung Cancer Conference – Multidisciplinary Care Friday, 30 June – Sunday, 2 July 2006 Novotel Palm Cove Resort, Cairns, Queensland www.alcc.net.au</p>	<p>Australia and Asia Pacific Clinical Oncology Research Development (ACORD) Workshop, a workshop in effective clinical trials methodology which will be held at the Novotel Twin Waters Resort, Sunshine Coast, Queensland from 3 – 9 September 2006. www.acordworkshop.org.au</p>
<p>The 17th Hospice New Zealand Palliative Care and New Zealand Pain Society Conference: Making a Difference Dunedin, New Zealand, October 2006. www.hospice.org.nz/conferences</p>	