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CONFERENCE UPDATES

11th IASP World Congress on Pain Official satellite symposia 17-20 August and 27 August—3 September www.iasp-pain.org/05satellitesymp.html	11th IASP World Congress on Pain Sydney, 21-26 August 2005 www.iasp-pain.org/05Cong.html
New Horizons 8th Australian Palliative Care Conference Sydney 30 August—2 September 2005 www.pallcare.org.au	International Institute of Palliative and Supportive Studies 2nd Annual South Australian Palliative Care Update 30 September 2005
Clinical Oncological Society of Australia 32nd Annual Scientific Meeting Brisbane Convention and Exhibition Centre, Brisbane 15-18 November 2005 Theme: Crossing Cancer Boundaries Call for abstracts –from both advanced trainees and COSA members Closing date – 2 nd September cosa@pharmaevents.com.au Please note: this conference has attracted a number of high profile speakers on topics of interest to palliative care health professionals	



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EDITORIAL

Since my arrival in this country two years ago, I have been struggling with the complexities of the Australian prescribing system. What is PBS approved, what is not, and if so for what indication? When do I have to fill out an SAS form (category A or B?) and which drugs need SDL approval? I am not helped by the very common use of trade names rather than generic drug names and the complications of authority scripting. Furthermore, there is the striking difference in the list of drugs that are readily available in the hospital in which I work, but which are cost-prohibitive to patients in the community. The most irking of all, is of course the lack of PBS approval for many of the drugs considered the “bread and butter” of palliative care practice elsewhere. The fact that patients dying at home have to buy their own midazolam never fails to amaze me.

This whole situation has been likened to a super tanker; huge and very difficult to move off course. Readers will be reassured to hear however, that the palliative care “tug boats” have been working very hard behind the scenes, slowly but surely nudging that super-tanker into line. In his excellent article, Geoff Mitchell (chair of the Palliative Care Medications Working Group Communications Subcommittee) explains who the tug boats are, what they are trying to achieve and why they have to work so closely (and often clandestinely) with pharmaceutical companies. Go Little Toot. The editor would welcome any letters on this topic and could direct any queries to the appropriate channels (pun not intended).

Another highlight of this edition is the article by Graham Hughes on spirituality and Uluru. I visited “the rock” with my family earlier this year. We were all struck by its majesty, but also by the fact that we seemed to be the only ones not attempting to climb it. According to the “Lonely Planet Guide”, climbing Uluru can be compared to clambering over the altar in the Notre Dame Cathedral or striding through a mosque at prayer time. Walk around the base next time, it is magnificent and solitary; great for anyone’s spiritual well-being.

We have updates on several of the projects coming out of PCA and good news on the proposed diploma course from the Royal College. As usual, Willie Landman has his priorities right in mentioning the rugby in every paragraph of his NZ report.

Janet Hardy
 Editor

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PRESIDENT’S REPORT



The ANZSPM executive met in Melbourne on Friday 15th May; it was the first time we had met face to face since being elected in Auckland.

Firstly, I am delighted to tell you that Dr Odette Spruyt from the Peter MacCallum Cancer Institute has agreed to join the executive, representing Victoria. After David Brumley and Michael Ashby stepped aside at the last AGM, we were left with no one to fill this important position.

Being President of ANZSPM has become a very substantive position in the last 12 months, as the Society has formalized relationships with Palliative Care Australia (PCA), the College of Physicians (RACP) and the Chapter (AchPM). The Society now has a voice on each of these bodies and various of their subcommittees. Much of what was discussed at the Executive meeting in May related to this new situation. A number of issues emerge:

- What is ANZSPM’s role and how does it maintain it in such an environment?
- How do the interests of members get represented in so many forums on so many different issues?
- Who is actually representing ANZSPM on various committees?
- How do we communicate these issues and their outcomes to the membership?

The answers to these questions are complex and we would appreciate receiving correspondence on this issue for publication in the Newsletter. One of the biggest challenges is that the Executive’s members are acting in an honorary capacity and have many other responsibilities (even sometimes seeing patients!). We are very fortunate to have the services of Kathie Thomas running the secretariat so that the organizational side of things runs very smoothly.

With regard to the PCA, we know have full voting rights but pay a hefty annual premium for that right. PCA are working on a number of projects which can be seen on their website. None is creating specific issues for the Society at present.

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In respect of the College, ANZSPM has a seat on the SAC for physician training in palliative medicine, although exactly who they are and what roles they play as ANZSPM representatives is unclear and needs clarification. ANZSPM also has a seat at the Special Societies Board, which met in Sydney in April. The main matter for discussion was the development of speciality-specific Clinical Indicators to replace those of the generic Australian Council of Health Care Standards (ACHS). The Executive is going to work on this. Clinical Indicators always pose a difficult challenge for palliative care, and any members who would like to contribute are invited to do so.

ANZSPM is also involved with the AChPM and the main common activities are speciality recognition and the joint diploma, both of which are moving forward, along their own bumpy paths.

We would like to try to do a stocktake of all the committees that ANZSPM is being represented on and by whom. If you are acting as an ANZSPM rep on a committee, please let Kathie Thomas know (secretariat@anzspm.org.au). If you are invited to do so in the future, also let her know.

Lastly, by now most of you would know that Dame Cecily Saunders died on 14th July, at St Christophers, aged 87. The BBC's obituary for her can be found at http://news.bbc.co.uk/2/hi/uk_news/4684505.stm.

See you all at the **AGM** in Sydney on **September 1st**.

Paul Glare
President, ANZSPM

Palliative Care and the PBS

The Palliative Care Medications Working Group (PCMWG) was initiated to address issues surrounding inequitable access to some essential palliative medications for patients in the community. Many of the medications used in palliative care are not subsidised through the Pharmaceutical Benefits Scheme (PBS). Patients who required these medications have to pay private fees for these medications or alternatively be admitted to hospital or attend a public hospital outpatient department to receive them through the state system.

The PCMWG provides advice to the Australian Government and includes representation from clinicians, pharmacists, peak groups such as Medicines Australia and PCA, the Department of Health and Ageing, the Pharmaceutical Benefits Advisory Council (PBAC) and the Therapeutic Goods Administration (TGA).

There was a lot of goodwill involved in seeing these medications on to the PBS in as short a time as

possible. Initially it seemed that it would simply be a matter of presenting the PBAC or TGA with adequate data and the rest would fall into place. However, the process has proved far from simple.

A joint survey of clinicians across Australia was undertaken by the Joint Therapeutics Committee, representing Palliative Care Australia, the Clinical Oncological Society of Australia and Australian and New Zealand Society of Palliative Medicine, to come up with a consensus list of priority medications. These medications were then categorised according to the degree to which they complied with all the requirements necessary to pursue TGA and PBS listing. For each medication, the following issues needed to be addressed, including whether:

- the drug was already approved by the TGA for a palliative care indication;
- the drug was approved by the TGA in a form suitable for palliative care administration;
- the route of administration used in palliative care was approved by the TGA;
- the drug was approved by the PBS for a palliative indication;
- the drug was approved by the PBS in a form suitable for palliative care administration.

Additionally, there was a need to establish if the manufacturer was willing to commit to the expense of preparing the necessary submissions to the TGA, and be willing to meet PBS requirements on price and to undertake a submission to the PBAC. If they were not, could funding be found to prepare the submission from elsewhere? Finally, if PBS approval was given, could a system be devised that was acceptable to the PBS to prevent unauthorised use of any new medication (so-called "leakage") and which encouraged quality use of medicines?

It soon became clear that this was far from a simple exercise and the Working Group has been working steadily through all the obstacles. Starting with those medications with the smallest hurdles, a process has been put in place and the mauve-coloured Palliative Care section in the Schedule of Pharmaceutical Benefits has come into being. The drugs in this section are those that have been the easiest to shepherd through the process. The group is steadily working through the list, currently tackling those medications where the requirements to be met are somewhat more difficult but not insurmountable. While it may appear to be a secretive process, it is important to work with all bodies involved, including the pharmaceutical companies responsible for manufacturing the

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treatments (music, aromatherapy, touch, etc) will have vastly different effects on different people, just as similar medications have different effects on different people.

I do not have good tools or advice for treating the spirit. I do believe, however, it is important to recognise that dying people do have a spiritual make up that is also profoundly affected by their situation. Treatment regimens should be prescribed in the context of recognizing the individual as a physical, psychological, emotional, and spiritual being, with all aspects interrelating. I believe that, like the Anangu, we feel pain in our spirit, even though we may not be as perceptive and aware of it as they are.

Is it any wonder that Palliative Care is considered as much an art as a science?

Graham Hughes
South Australia

Book review



"Loss, Change and Bereavement"
Eds Pam Firth, Gill Luff and David Oliviere
Open Uni Press, 2005

In recent years, Palliative Care practitioners have been overloaded by a plethora of books on grief and bereavement. This small book is a very practical guide to the whole process and is not difficult to read. For the newcomer to this area, it is a good summary of the subject, and contains many references to different papers and books for the reader who wishes to pursue a particular subject. The book consists of 13 chapters written by different authors on various aspects of grief and bereavement, giving a wide ranging overview of the subject. The first three chapters, particularly, are very useful for the historical perspective and description of more recent advances in the field.

Quinn, in chapter 1, gives a summary of bereavement theories to date, and describes bereavement care between palliative services as very variable. She feels we cannot distinguish the "high risk" person. She describes methods used in the UK, such as befriending, counselling, facilitated groups and telephone support.

Chapter 2 is titled "Mourning", and discusses the varied reactions to death. Mourning attitudes reflect the values and attitudes of the time, place and context in which they are occurring. In our society, there has been a decline in ritual and religious faith; death is viewed as a medical failure, and mourners are sent to a professional to be "healed". "Is grief an illness?" asks the author. The problematical behaviours, the pain and confusion following a death, are labelled as symptoms, and if the "correct" form of mourning took place these symptoms could be prevented. Theories based on psychoanalytical theory suggest that healing can only occur when the bereaved "let go" of their attachment to their loved one. Dependence on others has been seen as a negative

quality. The author felt that the goal of development is not independence but interdependency. As mourners, we do not "recover", but rather we adapt and accommodate the change, and develop a new perspective on life, and how it can and will be lived.

Chapter 3 discusses aspects of research, including the practitioners relationship with theory and knowledge base; entering and engaging the client's world of grief; and the organisational role necessary for managing research and ensuring services are grounded in evidence based practice. It was refreshing to hear that "listening is not simply a process of confirming what academic wisdom has declared to be "the case", but a way of recognising the power of clients to teach, with distinctive and individual insight, what is the nature of grief." She also discusses attachment theory, the concept of risk, and types of grief. There are some research tools to be used in grief, such as the Range of Response to Loss Framework, and the Adult Attitude to Grief Scale.

Jenny Aitchuler in Chapter 4 discusses the impact of loss on the individual and their family. "Systems Theory" places illness and loss within the context of interpersonal relationships. When diagnosed with a serious illness, each member of the family tends to move between grief and hope, roles change, including gender roles, and family dynamic change. As a health professional, we need to hold two dimensions in mind, the impact that illness has on the family, and the unresolved issues that predate the illness.

Life Review is the theme of chapter 5 by Jennie Lester. Life review recognises the importance of themes, eg family, career, health, love, hate etc. and the basis of the individual's meaning of life, set by values and beliefs. Clients can tell their story in their own way - spoken, recorded by audio, or video, as poetry, paintings or scrapbooks, diaries, or needlework.

Chapters 6 and 7 are concerned with grief and children. Jan McLaren points out that the grief of family members differ, and they need to understand each other's grief. The following chapter is concerned with interventions for bereaved children. The course and outcome of a child's bereavement is dependent on the quality of child care after the loss, the child's relationship with the surviving parent, as well as the child's risk and resilience. Her two dimensional model of childhood bereavement combines ecological and developmental models. She notes that bereavement care needs to be continued for a long time as children may develop symptoms and behavioural problems even after 2 years from the death of a parent.

I would strongly recommend this book as new insights may be gained even for the seasoned palliative care professional.

Jan Bowman,
Brisbane

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to snaffle Jonathan Adler as a new member, replacing Dawn White, whose maternal instincts are still dominant! The feedback on the meeting, and Joy Percy's organisation, was very positive.

Palliative Care in New Zealand is clearly in a development phase; with service specifications, workforce development, credentialing and training issues being addressed. This has accentuated the lack of a sustainable medical workforce with gaps in service delivery (especially after-hours cover) and has brought about discussion on professional safety issues. The gratifying aspect is that we are at least part of the national healthcare agenda.

4. Simon Allen has progressed the formation of a national palliative care umbrella organisation further, and further meetings are taking place with Hospice New Zealand and other stakeholders.

5. The rugby, the rugby.....

Willem Landman
Auckland, NZ

Spiritual pain

What could possibly inspire a bloke to sit at his laptop and write about such a heavy topic? Well, I am at Yulara, Northern Territory, the resort facility for Uluru (Ayers Rock). I am part way through a 2 week locum for the Royal Flying Doctor Service at the Yulara Medical Clinic.

Uluru is home to the Mutitjulu aboriginal community. The local aborigines (who call themselves Anangu), are derived from the Yankunitjatjara and Pitjantjatjara people.

To the white man, the rock commands an awesome presence. The rock emerges from the red soil, and has a strength and a mystique which is difficult to put into words. It generates a feeling, that has a physical component. It seems to be a living being, particularly when it changes colour with the setting or rising sun. I have been lucky enough to see the rock during heavy rain, and witness water cascading from it, creating spectacular waterfalls and lakes at its base. Uluru's "personality" seemed different again at this time. It is no wonder that Uluru has been the subject of many songs, literature and film over the years and remains an icon that symbolizes Australia.

The comments above describe Uluru from a white man's perspective. The Anangu people view Uluru from a much deeper spiritual viewpoint. They believe Uluru was created during Tjukurpa, which we call the Dreamtime. The Anangu translate this word to mean "creation tim", because it has nothing to do with dreams. They believe the land was created by their ancestors, spiritual beings with characteristics of both animals and humans, who could interchange between both. As they traversed the

country, important events took place, leaving energy in the ground at specific places. Here, mountains and rivers were formed, and the energy remains. The Anangu are still affected by this energy today, hence the many sacred and spiritual areas they respect. The events of their ancestors not only resulted in geographical structures being formed, but also laid down the laws and customs for their traditional culture, much of which influences their beliefs and practices today.

Uluru's history abounds with stories from Tjukurpa. The rock, according to Anangu history, was formed by two boys playing with mud after the rains. Many of the features on the rock are representative of battles that occurred between their ancestors, both in human and animal form. Many of these ancestors still live on and around Uluru.

Today, the Anangu manage the Uluru National Park, and welcome visitors. Walks around the base of the rock indicate a lot of features describing events of the Tjukurpa. A very popular activity of visitors over the years has been to climb Uluru. This climb is not for the faint hearted or the unfit, as the climb is dangerous and dozens of visitors have been killed in the attempt. The Anangu allow people to climb Uluru, but respectfully ask people not to. The decision is left up to the individual, but it is certainly the preference of Anangu that visitors respect the sacred, spiritual significance of Uluru and keep off it.

I had the opportunity to talk to an elderly Anangu man, and I asked him more about this. He told me that many living ancestors were "in" Uluru, and that the people feel "pain in their spirit" when they see non Anangu climbing over it. He used the term spiritual pain as if I would know exactly what he meant.

I believe we all have a significant spiritual aspect as part of our make up. By this, I do not mean religion, although religion does contribute to our spirituality. The Aboriginal people are more explicit about their spiritual make up, and they more readily identify it to themselves and others. Our culture perhaps buries this spirituality, making it harder to identify, and its nature varies enormously from person to person.

When we are facing death through an illness, our spirit also hurts. This influences the way we react to the prospect of death, and also significantly influences the way we respond to treatments, both medication and supportive. I have never seen two people with exactly the same disease respond to the same treatment identically. Different supportive



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medications. This includes recognition of the commercial-in-confidence nature of some of this information. Ultimately, it is the prerogative of the manufacturer as to whether the process required for each drug will be taken to fruition - it is a commercial decision.

We have been delighted with the wholehearted support we have received from the Australian Government National Palliative Care Program, the TGA and the PBS. Moreover, many manufacturers are willing to participate in the process. The committee has also learnt a lot about the thoroughness and integrity with which the regulation of our drugs is undertaken.

In summary:

- everyone has had to become familiar with a complex regulatory process, and devise strategies to meet these requirements;
- the whole process has to be undertaken for each drug individually. We are at the start of what will be a lengthy process. Not all drugs on the list will make it but many will; and
- a practical and feasible process has been developed to ensure that drugs listed for palliative care on the PBS are used for that purpose only.

Now the process has been established, it is time to encourage widespread use of the "mauve pages". Those of you who do not possess a copy of the latest edition of the Schedule of Pharmaceutical Benefits are encouraged to contact National Capital Printing (sales enquiries: ph 02 6283 0055, fax 02 6280 7875). It is hoped that this article will provide a better understanding of why so little seems to have been achieved to date.

Geoff Mitchell
Palliative Care Medications Working Group
Chair Communications Subcommittee

Diploma of Palliative Care

The working party for the Clinical Diploma of Palliative Medicine were notified in May that the Federal Government's Department of Health and Aging had agreed to provide funding to assist in the development of the diploma. As these funds will be administered by the College of Physicians, guided by the steering group, they are signatories to the agreement. A Project Officer, Elizabeth Quine, has now been appointed. Elizabeth works within the Education Department of the RACP and will work with the steering group to finalise the curriculum structure and content, clarify the assessment processes, investigate learning and teaching resources and generally promote and market the diploma. The time frame is fairly tight as the project has to be completed and reported on by the end of June 2006. There is also provision within the funding agreement for a small pilot of the diploma in 2006. Fellows of the Chapter of Palliative Medicine were invited to volunteer as supervisors for doctors participating in the pilot and 10 sites have applied. Only 4 will probably be required, so the suitability of each site will be determined by set criteria. It is good to see this project gaining some momentum and it will be immensely rewarding to see the finished product in place.

Pat Treston
Chairman, Diploma Steering Committee

Notice to prescribers:

Paracetamol in modified release preparations is now available on the PBS with a palliative care listing.

National Breast Cancer Centre leading the way in multidisciplinary cancer care

The National Breast Cancer Centre has released Australia's first practical guide to assist clinicians and health managers with the planning and running of multidisciplinary cancer care meetings. The National Breast Cancer Centre's guide "Multidisciplinary meetings for cancer care: A guide for health service providers", offers health professionals practical ideas and tools to improve multidisciplinary cancer care at a local level. The new guide features case studies in setting up a team and implementing teleconferencing as well as a generic treatment plan proforma and checklists for planning and running a team meeting.

The National Breast Cancer Centre is continuing its work in the area of multidisciplinary care through a series of forums across the country to promote this approach to care for all cancer patients. Details of upcoming forums can be found on the National Breast Cancer Centre's multidisciplinary care website www.nbcc.org.au/mdc. The meeting guide can also be downloaded from this site or can be ordered by calling 1800 624 973.

The National Breast Cancer Centre is funded by the Australian Government and works with women, health professionals, cancer organisations, researchers and governments to improve health outcomes for women with breast and ovarian cancer.



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Using CareSearch to find evidence and information

CareSearch is a website developed as part of the Evidence Based Palliative Care Project. It can be found at www.caresearch.com.au. The project was designed to capture palliative literature and research that was undertaken in Australia but might not be easy to access through the formal literature channels.

Sackett and his colleagues in 1996 described Evidence Based Medicine as "the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients". But what happens when such evidence and knowledge is not easily available or is only partly accessible? In palliative care, finding answers to clinical and practice questions can be difficult. Much useful information may only have been presented at conferences or in reports to state or federal departments; not everything is published in peer reviewed and electronically indexed journals.

CareSearch is designed to assist palliative clinicians in accessing evidence and information in three ways:

- by stockpiling the evolving research and knowledge base within Australia in a literature database of conference abstracts, non-indexed journal articles, theses and grey literature items to complement the literature indexed on the major bibliographic databases
- by creating PubMed search strategies on topics of palliative importance that can be directly loaded in the Medline database for immediate searching, and
- by providing links to databases and websites of use to palliative care providers.

Accessing the CareSearch site:

The website is found at www.caresearch.com.au. From the homepage you can move to different sections of the website by clicking on the five tabs at the top of the webpage. You can also move to different pages by clicking any highlighted words in the text.

Using the CareSearch literature databases:

There are nearly 3,000 items held in the CareSearch literature databases. Together they provide a developmental history of Australia's palliative practice and a rich repository of research and service information. The four databases (conference abstracts, non-indexed journal articles, theses and grey literature) can be searched individually or collectively. If you are interested in finding out about the work of a particular researcher or clinician you can search by author, or you can search by a textword of interest. For example, entering nausea as a keyword and ticking conference abstracts as the type of literature retrieves 76 items presented at various conferences in Australia since 1980.

Running a PubMed search:

We currently have 11 PubMed search topics held on CareSearch. To find these searches click on the Search Strategies tab at the top of the website and then click on the highlighted PubMed in the Search Strategies page. This will take you to a table of prewritten searches.

Suppose I am interested in cachexia, I can choose to find as many references as possible by clicking on the sensitive search in the first column ("retrieve references"). This will find 2,174 general items related to cachexia. If I was interested in a more refined search I could look for only systematic reviews by clicking on "SR" in the third column. This would find 14 systematic reviews. Similarly I could choose a sensitive or specific search of RCTs dealing with cachexia and find 198 articles and 55 articles respectively. If I wanted to read full articles immediately, I could select the full text option and retrieve items that had full text freely available.

Selected databases and weblinks:

The last area helping clinicians to access literature and evidence is through selected links to other websites and resources available online. A selection of resources relating to clinical support materials, audit and tools, research, and organisations and agencies can be found in the resources section of the website.

CareSearch directions:

New material is currently being developed for the website and will be added over the next few months. This includes additional search topics for use in PubMed and new clinical pages dealing with aged care, caregivers and palliative medications. New pages on educational and training options and short courses should be available by mid August.

We do appreciate feedback on what would be useful to help those in the palliative community. We also produce a bimonthly newsletter, CareSearch eNews, which highlights changes and additions to the website and promotes new resources and reports available on the web. To register for the eNews or to send us comments or ideas, please email Jennifer.Tieman@flinders.edu.au

Jennifer Tieman
Project Manager,
Evidence Based (CareSearch) Project

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Paediatric Palliative Care Resource Project

Background

In 2003 the Australian Government Department of Health and Ageing, as part of the National Palliative Care Program, commissioned a study which examined the ways in which paediatric care is delivered in Australia. The final report was published in January 2004. Amongst a range of recommendations the report called for the provision of "comprehensive and timely information about both the clinical and management aspects of paediatric palliative care...to provide support to families (particularly in rural areas), local health care professionals, community hospitals and other relevant organisations".

Project Details

As a direct result of this recommendation, Palliative Care Australia was contracted by the Australian Government Department of Health and Ageing to develop a national resource guide for paediatric palliative care. This resource will be targeted towards carers of paediatric palliative care patients, particularly those in rural and remote areas. It will provide reliable information about quality resources, as well as clinical and social support services available both at a national and state level. The aim of this project is to maximise the accessibility of existing resources and services particularly to those people living in rural and remote areas.

The priority of the Paediatric Palliative Care Resource Project (PPCR) is to make sure that the resource is of high quality, accessible and consumer focused. To achieve this the project is being developed with the ongoing assistance of a Project Reference Group consisting of specialist paediatric palliative care clinical service providers and consumer organisations and a Carers Reference Group consisting of carers from both rural and urban locations.

A comprehensive Consumer Consultation has also been conducted. This consultation found there was a strong desire for both a written and web based paediatric palliative care information resource, but that the need for a quality written resource was more immediate. Consequently the decision was made to produce a hard copy resource guide in a format that can be easily updated and distributed. It will also include brief summaries of key issues, advice on questions to ask, checklists on things to be thinking about, lists of other quality resources, services and information available in regional areas and some carers stories.

The Project is now at a very busy and creative stage. The first draft of the resource is currently in development. The Project Reference Group is working

extensively in assessing existing resources for inclusion in the PPCR and the Carers Reference Group is providing invaluable expertise on its format and content.

The Paediatric Palliative Care Resource will be produced both as a hard copy folder and in electronic form and is due to be released at the 8th National Australasian Palliative Care Conference in Sydney at the end of August 2005.

Sarah Jones

Paediatric Palliative Care Resource Project
Coordinator, Palliative Care Australia
email: sarah@pallcare.org.au

NEW ZEALAND NEWS

In true palliative care style, FIRST the bad news:

1. The dearth of Palliative Medicine specialists and GP's with a special interest continues, only to be matched by the lack of resources with which to address this issue.
2. It is a sad reflection on our modern society that some people can only find their voice through perpetrating acts of extreme violence to their fellowman, such as we witnessed with the recent London bombings. Our thoughts go to our colleagues with British connections (quite a number!), who must have suffered some anxieties about their friends and families back home.
3. The state of the British and Irish Lions rugby union teams and their coaching staff.

Now all the good news:

1. We have just been given the opportunity to comment on a draft Ministry of Health document on Workforce Development in New Zealand, and it looks very positive, if a bit far away.
2. The rugby: The All Blacks having white-washed all the aforesaid British and Irish Lions. The supporters club of above Lions team- a wonderful bunch of ambassadors for the British way of life.
3. ANZSPM New Zealand had a great annual meeting in Wellington at the end of June, for the first time, combining with the Hospital Palliative Care New Zealand (HPCNZ) group. There is a significant overlap in medical officer membership between the two groups, and the presence of the nurse specialists from HPCNZ gave a multi-disciplinary flavour to the meeting. As it turned out, the nurses brought some real "joie d'vivre" and considerable expertise to brighten up proceedings. Each group had its own meeting, but shared social functions and a clinical learning day. The executive has managed



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