

ANZSPM

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Send Articles to: The Editor, ANZSPM Newsletter,
Dr GB Crawford
Clinical Head of Palliative Care
Lyell McEwin Palliative Care Service,
Haydown Road, Elizabeth Vale, SA 5112
email: editor@anzspm.org.au
if you prefer, fax to: 08 8182 9808
Or use the web site: www.anzspm.org.au

EDITORIAL

At present it is cold and very wet in Adelaide, the capital of the driest State in the driest continent and we are about to have water restrictions imposed. Yet by September it will be balmy and the place to be for the 7th Australian Palliative Care Conference - 9-12th Sept 2003 at the impressive Adelaide Convention Centre. There will be an AGM of ANZSPM and the program looks excellent. "Time to Reflect." On line registration is at www.pallcare.org.au/pca_conference.html

In this edition there are letters to the editor about Michael Ashby's article "Nancy Crick, Assistance to Die and Palliative Care" and Michael's response. The media continues to pay attention to ethical dilemmas and end-of-life decision-making - the most recent being Gardner; re BWV in the Supreme Court of Victoria. This decision was the first time that an Australian court has ruled on whether tube feeding could be ceased. The decision hinged on what was palliative care and what was medical treatment, as a patient's agent cannot legally refuse palliative care in Victoria. This ruling makes the legal position in Australia similar to that in England and Wales and is likely to give a common law precedent for other cases.

There has been more media flurries around carbon monoxide machines and some of you may have seen a questionnaire seeking information about end-of-life decision making - particularly how decisions are reached about drug doses and intention. Questions with two different concepts in the same stem can only result in ambiguous or frankly misleading responses and direct concerns have been relayed to the ethics committee that approved the study.

Graham Hughes has contributed a moving and very personal article that I am sure will resonate particularly with those of you working in small communities over time. The challenge is to see when a professional boundary is likely to be crossed and to decide if by crossing it the benefits might outweigh the risks.

And congratulations to Professor Lickiss who has been awarded an AO in the Queen's Birthday Honours. Official recognition of her vital work but also for palliative medicine and the care of those with a life-limiting illness.

All good wishes

Greg Crawford, Adelaide, June 2003

PRESIDENT'S SOAPBOX

In mid-February we had our first formal face-to-face Council meeting at Calvary Hospital in North Adelaide. It was interesting for me to be back next to the Mary Potter Hospice where I first started as a palliative care specialist in 1989. The genteel dignity of the Parklands and North Adelaide with its fine mansions, workers' cottages and Anglo-Australian gardens, an oasis of green and cultivation in the midst of the driest state (in fact it rained throughout my stay) - worked its homely spell for me. I always feel a strong sense of place and personal history, so I took some time out to recall what it had been like in my early days in this field. Palliative care was wide open then. Most of us taking up new positions in the 80's had no specific training for the task, and brought our skills and experience from other disciplines, in my case some general medicine followed by what was then known in the UK as Radiotherapy and Oncology: a broad general solid tumour training with emphasis on radiation treatment planning and delivery. You learnt a lot about cancer, and how to work out symptom mechanisms and plan appropriate radiotherapy. One also had to do most of the basic ward management, cancer supportive and palliative care. I can clearly remember the first week that Geoff Hanks arrived at the Royal Marsden Hospital in Sutton and started to show us there was more to palliative care than I had thought (I was very attached to aspirin and nepenthe I seemed to recall, and tended to think that diamorphine dose escalation was the only other thing to know!).

I really didn't know much about hospice care and the staff at Mary Potter were very forgiving and tactful as I learnt from them and then we learnt from each other, by reading, travelling and having visitors ourselves. There was quite a gap between hospice and acute hospitals, and oncology and we set about narrowing it. We tried out new pain regimes and initiated some small research projects. We were all pioneering and there was a spirit of adventure and challenge.

In just over a decade palliative care courses and diplomas abound. You can do FRACP in Palliative Medicine and we have formed the Chapter. The field is imbued with management, strategy, quality assurance and more rigorous research. Maybe it is just as well that you can't start like I did now, but sometimes when I look at all the structures and baggage we surround ourselves with now, I feel a real dept of gratitude for

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those wonderful colleagues who allowed me to develop my practice 'on the job' a decade ago. Most of the challenges remain, and despite all the collective achievements of the palliative care world there are still days in my present hospital where it feels just the same as that first day I walked into the Royal Adelaide Hospital to do hospital consultative work before we even knew what to call it! It was very special to be 'back' in the new Robson Lecture Theatre with many of one's RAH colleagues of those times to give a lecture arranged by Mary Brooksbank, my colleague and successor. Greg Crawford arranged a very enjoyable dinner with local doctors to increase awareness of ANZSPM, and give colleagues a chance to meet each other. Several trainees gave me a first hand account of some of the difficulties of doing chapter training, matching our requirements with available jobs can be very trying.

This visit to Adelaide is part of a policy of intending to move Council meetings around the country and try to link them to some kind of Palliative Medicine meeting or related event. The next one will hopefully be in mid-year in Sydney.

The new Council had 'full and frank' discussions concerning the role of the Society. Whilst there was a wide range of views, there seemed to be a consensus that ANZSPM should advocate ('politically' when necessary) for palliative medicine, both specialist and general practice, as nobody else will. ANZSPM offers an important channel for collegial exchange and support, and for communication with the rest of medicine. There was clear support for our role as the recognised special society for Palliative Medicine with the RACP. Council also supported the concept of a diploma linked to six-month jobs for general practitioners, and hoped that the relevant colleges would be able to progress this. I will also be having discussions with David Currow about enhancing our relationship with PCA.

Graham Hughes encouraged us to look at being of more practical relevance to GP's, and there was enthusiasm for web-based prescribing and treatment information.

In order to foster state-based ANZSPM activities we are looking to have a network of local convenors to foster existing links and meetings and promote new ones. We also agreed that we should look at providing financial support for remote members, and those working in the NT and ACT, to attend adjacent state meetings. We also need to co-opt WA representation to Council.

Two ANZSPM colleagues who were involved in the care of the late Nancy Crick have written in response to my article on the case reproduced from Monash Bioethics News in the last

newsletter. I understand their frustration at being unable to set us straight about how it really was for the staff involved because of the overriding obligation to respect their patient's confidentiality. I want them both to know that I did not in any way intend to criticise their management, and would extend to them, as I do to all our members, the traditions of professional solidarity that have been the hallmark of our society. I certainly would never want any rural or regional colleague to feel a sense of the big city 'know it all' either. I simply made some points based on what is in the public domain; most notably that Nancy Crick's case cannot be used to say palliative care 'failed'. I also tried to emphasise some specific difficulties that we all experience, such as managing pain and other symptoms where there is no objective evidence of cancer recurrence. Most of all I wanted to say that whilst we can usually improve things, our best efforts cannot always make our patients want to continue living. I am not sure that palliative care was given a fair or long enough go by Nancy Crick, which is very different to saying that what was done was no good.

I have recently written an article with my legal friend Danuta Mendelson on the recent tube feeding case here in Victoria (Ashby M, Mendelson D. Natural death in 2003: are we slipping backwards? *Journal of Law and Medicine* 2003;10:260-264.). I would be happy to send a copy to any interested member. This issue of artificial hydration and alimentation is a perennial source of confusion and apprehension in the acute and aged care sectors.

Palliative Care Australia has recently asked us to endorse their Planning Guide 2003. This is an important document for the future development of palliative care in Australia, and subject to Council approval, I will write to endorse it next week. It sets out proper medical staffing levels, and finally recognises hospital-based palliative care. Please all read it and help in the task of getting it put into practice. We have a long way to go in improving medical workforce numbers in Australia and New Zealand. I have just written to our Palliative Care Victoria chairperson Allan Kellehear pointing out the low number of sessions and positions in this state, and he has agreed to raise the issue in a forthcoming ministerial meeting. This was brought to a head for me when I heard that one of our colleagues couldn't get cover to go on maternity leave. Any other stories like this? What about a national campaign? Please fill our postbag!

Michael Ashby
Melbourne
April 2003

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LETTERS TO THE EDITOR

As far as I am aware, I am the only member of ANZSPM to have had any direct contact with the late Nancy Crick. As a result, I am heartily sick and tired of the many commentaries that have appeared in the lay and medical press about her case from various 'experts'. Having been harassed by the press and having had my confidential medical reports to police leaked to the media within hours of delivery, I vowed six months ago to have no more to say about the whole tawdry matter. However, I feel I must respond to Michael Ashby's recent 'ethics' piece in the ANZSPM newsletter of November 2002.

Commendably, Professor Ashby has always had the grace to state his own personal feelings about euthanasia openly, and he does so again in this newsletter. Furthermore, I agree with Ashby that "the specific narrative (now) informs the general" in public ethical debates. But I am still amazed that no member of the medical profession who was happy to have had his or her opinion on the Crick case aired in the press ever bothered to ask their colleague who actually treated the patient to check the clinical details. Surely even casuists need to check a few facts before they start absolving their consciences. (I should note that I thought Ashby's use of 'casuist' twice in his first two paragraphs was unconscionable!) I believe Ashby's whole argument is fatally flawed simply because it is based entirely on information reported about Mrs Crick by the news media. The precise clinical details of Mrs Crick's sad case would raise the eyebrows of most medical practitioners but they will remain undisclosed by me out of respect for her medical confidence. The breathless daily media reports about Mrs Crick were nearly all lifted directly from her page on the "Exit Australia" website and these offerings were written and mounted by others. I do not believe it is divulging a medical confidence to reveal that Mrs Crick stated to me, and to a community nurse who cared for her up until the day before she died, that she did not know anything about computers and did not control what was put on her web page.

Those of us trying to offer high quality palliative care on the Gold Coast have also been uninspired, if not insulted, by the almost uniformly condescending words or implications from capital city based experts about Nancy Crick's case. We may be a provincial centre with lots of beaches and theme parks but that doesn't mean we don't have a modicum of knowledge and dedication. And I am certain we have a bigger caseload than any capital city teaching hospital palliative care service.

I cannot finish without a comment on the Hugh Mackay comment "she tried palliative care and it didn't help her". Based on her widely reported timetable, Mrs Crick had nine days to live when she entered the Palliative Care Unit, St

Vincent's Hospital, Robina (now Gold Coast Hospital, Robina). She spent nine days in our Unit and was discharged with community palliative care nursing support. She ended her life six weeks after discharge; six weeks after she had originally promised to do so.

As I see it, the influence of palliative care was to extend her life by six weeks. Weeks she spent with family and friends in the comfort of her own home. If I published a clinical trial about a new cytotoxic agent that achieved six weeks' extension of life, with quality, for people with advanced malignancy, it would be the new standard of care overnight! How then can it be said that palliative care didn't help?

Robert Hitchins

As a long-standing member of ANZSPM I would like to record my extreme disappointment on reading Michael Ashby's ethical dissertation on the Nancy Crick affair.

Ever since the story became public, those of us who were directly involved in the management of the late Mrs Nancy Crick have been extremely frustrated by our inability to respond to criticism of our management because of the issue of patient confidentiality. The duty of confidence owed to a patient persists beyond death. I refused to provide any information in respect of my consultations with Mrs Crick to the media despite numerous requests. My involvement in the case was reported widely in the lay press following the leaking to the media of my statement to the police. I continue to refuse to comment about the case except to state that the issues were far more diverse than is generally appreciated.

I expected the feeding frenzy of the lay press, I was disappointed by the clinical criticisms of colleagues who were unaware of the facts surrounding the case, but I was bitterly disappointed by the not so subtle implied criticism of Michael Ashby in the latest issue of ANZSPM Newsletter.

Professor Ashby acknowledges the fact that the issue of patient confidentiality precludes us from disclosing the clinical facts and then proceeds to imply that the situation would have been better managed elsewhere in the country. I strongly question the ethical implications of this approach. How can we promote the concept of palliative care to the lay public when those of us who practice it do not support each other?

Dr Barbara Craig
Visiting Medical Officer, Palliative Care
Gold Coast Hospital, Southport Campus

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Dear Dr Hitchens

My purpose in reproducing the article in our Newsletter was to contribute to an on-going debate, so your response is welcome. I do, however, feel that I in turn need to respond to some of the points you make, and seek some further clarification of comments which I did not fully understand.

Firstly, I do understand your frustration at seeing others commenting on a case of which you have sole first hand knowledge. The feeling of 'armchair' expertise being offered from the sidelines is never comfortable. Also, all of us have been frustrated by misrepresentation of palliative care in the media over the years.

Secondly, you appear to have taken my article to be critical of your unit and its clinical capabilities.

Let me be clear if I was not in my article. I in no way sought to disparage your unit, and thought that I had made this clear in the final paragraph. However, in the 9th paragraph ("her brief admission to a Gold Coast Hospital for palliative treatment was not enough") I accept that this might be one reading of it, but not one that struck me until now. My point was that I did not, and still do not, think that the usefulness of palliative care should be judged by this one admission, to any unit, however good, and this was the impression I got from press comments, a point with which you clearly agree. The 'enough' was about overall care throughout her illness, not your unit. And I clearly state later on that maybe none of us could have improved Nancy Crick's lot.

I wrote the article because I was asked to. It did briefly cross my mind to try and locate the palliative care specialist concerned (I did not know who that was but could have found out), but dismissed the idea, assuming that if you had wished to go public you would have done. The reasons for you not being able to do so are clearly understood and stated by both of us. I therefore dealt with the case as presented in the media, and speculated about what might have happened, knowing that the forensic data could probably only be revealed in a legal setting. I believe that these clinical speculations were reasonable in the circumstances, and you do not correct them (unless you felt that you could not for reasons of confidentiality but you do not state this).

I was puzzled by your strong censure, with moral overtones ("unconscionable") of my use of the term 'casuistry/tic', and could only think that you thought that I could not make this claim in the absence of forensic data. I used the term merely to describe what was happening in the Australian media at the time, that is, much generalisation from a case about which there was very limited clinical information in the public domain.

Your placement of the word 'ethics' in quotation marks also suggests some kind of attempt to disparage my 'piece' although maybe now I am being over-sensitive. It was published in a bioethics journal, as a piece of journalistic comment, not as an academic or philosophical work, so maybe it fails your 'ethics' test on those grounds.

I was most puzzled by your implied comment that I was 'absolving my conscience', and I can assure you that I did not feel then and do not feel now any need to do so. It would be good to know what I should have been so troubled by. I wrote the piece to defend palliative care/medicine from the charge that it had been tried and found wanting, and tried to point out some of the difficulties clinicians would have faced in cases 'like this', my 'argument' was no more or less than that. I am sorry if this was not clear, or if in the process I have seemed to you to be displaying 'big city' arrogance, which I dislike as much as you do. Strangely, I think we probably agree on many aspects of the clinical palliative care issues at stake here, although we probably differ on how the field should respond to euthanasia. And lastly, yes, if I were you I would also be sick of reading about a case in which I was involved, but was unable to comment on. Perhaps deep down I had a sense of speaking for those who cannot speak, always a dangerous game. Perhaps I should have called you, and maybe you would have told me that palliative care did help Nancy Crick.

With best wishes
Michael Ashby

NATIONAL INSTITUTE OF CLINICAL STUDIES

ANZSPM has two representatives on the National Institute of Clinical Studies (NICS). This is a multidisciplinary advisory committee, chaired by Prof. Sanchia Aranda, to guide the planning and implementation of a national evidence-based pain management improvement initiative. The first meeting is to be held in Melbourne on June 18th, but the committee will meet at various locations subsequently.

Many thanks to Paul Glare in Sydney and Sarah Pickstock in Perth for their endeavours on our behalf.

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EDUCATION FOR PHYSICIANS ON END-OF-LIFE CARE

In April 2002 I journeyed to Santa Fe, New Mexico to attend a course for physicians on end-of-life care. I found out the Americans had really got stuck into this widespread educational initiative begun by Linda Emmanuel MD PhD at the Institute of Ethics of the American Medical Association in 1997.

The EPEC curriculum was designed with input from nationally respected experts in the field of ethics, hospice and palliative care. Linda Emmanuel sought the help of Charles von Gunten, Frank Ferris and Russell Portenoy. The EPEC project was supported by a grant from the Robert Wood Johnson Foundation. It was an ambitious initiative designed to educate all physicians on the essential clinical competencies in end-of-life care. Central to the success of the project was a standardised core curriculum. Since the curriculum was first published in late 1999 it has been evaluated by many physician educators and then developed further.

The curriculum consists of didactic sessions, videotape presentations, interactive discussions and practical exercises in a clear and concise format. There are 4 plenary modules and 12 workshop modules. It teaches fundamental skills in communication, ethical decision making, palliative care, psychosocial considerations and symptom management. The curriculum can be adapted to non-medical audiences as well. It probably is best described as having a potential to have a powerful ripple effect in palliative care education throughout the United States. The program was launched at the American Medical Association and was part of the AMA website initially. This enabled the EPEC team to interact with over 96% of American physicians. The EPEC project has proceeded to hold regular "train the trainers" conferences since 1999 and has to date trained almost 1000 physicians in basic competency skills in end-of-life issues. These 1000 have in turn educated many others using the EPEC curriculum.

When I arrived in the beautiful city of Santa Fe, I found I had some apparent status in being the only Aussie on the course! Fortunately, one of the presenters James Cleary (Medical Oncologist) was also from Australia but has lived and worked in the United States for a number of years. He befriended me and we happily provided the Australian viewpoint (enthusiastically) on a number of issues from time to time. I was stretched professionally and personally as I struggled through some of the curriculum on advance directives, medical futility, role plays, debates etc. I found it a stimulating experience, which was embellished by the hotel piano player who accelerated my homesickness by wonderful renditions of some of Peter Allen's music.

I reflected on the course on the way home. Why couldn't we do something similar in Australia? I had left a copy of our Clinical Guidelines in Palliative Care with the Co-Principal of EPEC Frank Ferris. There was some interest from one or two members of the of the EPEC team faculty, in the use of the

EPEC curriculum for other parts of the globe. Perhaps a similar approach to EPEC could be undertaken here in Australia. It would be a useful initiative for us to have a defined curriculum (the EPEC curriculum together with our own Undergraduate Curriculum is a good start and our Clinical Guidelines is another source which we could use). Eventually such a curriculum could be offered Australia wide to undergraduates, postgraduates and it would have to be adaptable for the multidisciplinary setting. The curriculum would be dynamic, requiring regular updating as new concepts became established. We would need to work with the colleges to provide sufficient CME points to entice many to do the course (the Americans provide 19 points). Most importantly we could demonstrate by pre and post testing, that the course makes an impact on medical practitioners' ongoing professional education, and perhaps even attract government support. I am returning to Chicago next year to attend a refresher course and update my skills on adult learning techniques.

I have brought this to the attention of the ANZSPM council and the Chapter of Palliative Medicine in the College of Physicians. Hopefully others will share my view.

John Cavenagh, Newcastle, NSW

QUEEN'S BIRTHDAY HONOURS

Officer (AO) in the General Division

Congratulations to Professor Norelle Lickiss on being recognized for her outstanding service to the development of palliative medicine in Australia. Prof. Lickiss is Clinical Professor (Medicine) at the University of Sydney and has been a consultant physician (palliative medicine) Royal Prince Alfred Hospital since 1985. She established the Department of Palliative Medicine and was Director of Central Sydney Palliative Care Service from 1985 to 1998. She was Director of Palliative Care, Prince of Wales Hospital, Randwick and conjoint associate professor, University of NSW from 1991 to 1999 and consultant physician (palliative medicine) at the Royal Hospital for Women, Paddington, NSW.

Prof. Lickiss is Founder and Director of the Sydney Institute of Palliative Medicine. Since the late 1980s she has focused on postgraduate clinical training in palliative medicine for doctors, (in Australia, UK and Asia) preparing for careers in palliative medicine or other specialties including family medicine. She is a Fellow of the Royal Australasian College of Physicians and a Foundation Fellow of RACP Chapter of Palliative Medicine. She holds an MD (doctorate thesis: The Aboriginal People of Sydney with Special reference to the Health of their Children: a study in Human Ecology, 1971.)

We all congratulate her and wish her well.

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HOW CLOSE IS TOO CLOSE?

Many of us will have cared for friends during their terminal illness. This will particularly be so for GPs working in a rural community. The following is a personal reflection of such an instance, which finished just a few weeks ago, when one of my very closest friends died under my care.

I will outline the social setting, and our relationship, and follow with a brief outline of the clinical course of her illness. Following this, I will discuss a few issues relevant to the complex dual role of friend and doctor.

Diane, Mark, and their 3 children had been close friends of our family for 12 years. Our relationship was so close, that they had made a deliberate decision not to see me for their medical care, as they thought this may compromise the friendship. We shared meals regularly, and I played golf with Mark weekly. We holidayed together frequently, including a beach camping holiday on Adelaide's south coast each January. We supported each other during the past 12 years through various difficulties, as close friends do. Our children go to school together, and play sport together, as is typical in a rural community. Diane was particularly supportive of my work and further study in Palliative Care. She had developed a keen interest in bereavement counselling, and used her BA (Psych) extensively in her work as a funeral director.

In January 2001, at age 37, Diane discovered a lump in her breast. She saw her GP, and mammography followed by needle biopsy confirmed the diagnosis of breast cancer. Routine initial investigations confirmed the presence of spinal metastases at multiple levels. Chest X-ray and bloods were clear at this initial stage.

I provided support for her and Mark at that stage, but already this role was difficult, because they clearly did not understand the grave significance of the staging of this cancer at diagnosis. Although reluctant to ask, they were keen for me to 'fill in the gaps' and 'read between the lines', of specialist comments, on their return from appointments.

I first 'interfered' when I visited Diane in our local hospital, where she had been admitted for control of nausea and vomiting, during the night after her first dose of chemotherapy. She was being treated with IV fluids and Metoclopramide, with no relief. Reluctantly, I suggested to the RN that she ring Diane's GP (from the friendly opposition practice in town), and ask if Tropisetron might be worth a try. I had not wanted to get involved, but it was just impossible not to.

Shortly after that episode, Diane and Mark came to see me and tearfully asked if I would look after her from that point. Diane was particularly concerned about feeling vulnerable within our

relationship, and the first physical examination I performed was very difficult for her. Fortunately this became easier as time went on.

Her clinical course over the next 18 months was stormy and disappointing. She had a course of chemotherapy, followed by mastectomy with axillary clearance. This was followed by bilateral oophorectomy. Subsequent bone scans revealed widespread skeletal metastases. She developed liver and lung disease. A second course of chemotherapy was delivered during late 2002, with apparently good results. Her bone scan appeared encouraging with some degree of regression of metastases.

In December 2002, however, Diane developed pain associated with pelvic and vertebral metastases, and I admitted her to hospital for pain management and referred her to Adelaide for outpatient radiotherapy. Her pain was difficult to control, requiring escalating opioid doses. On one particularly difficult weekend, I was away for 2 nights for a weekend off, and managed her by phone. This was a mistake, as I will discuss later, and she developed a severe delirium (a result of the escalating opioids), was corrected upon my return, but was a source of great distress for Diane and her family.

Diane went home for Christmas, but developed blurred vision, due to intramedullary and retinal disease. Her lung disease became worse, with increasing dyspnoea. By early January 2003, our mutual goal was to keep her well enough to go on our annual holiday together. This was, in fact possible, and our two families enjoyed a week together, although Diane was severely restricted and largely confined to a chair, with extremely limited mobility and breathing capacity.

Two weeks after returning from holidays, Diane became acutely short of breath, due to a combination of lung disease and anaemia. I admitted her and transfused her, but she had developed a myeloblastic and haemolytic blood picture, and it was clear she had entered a terminal phase. I had to deliver this news to Mark and Diane, and it was distressing to inform my closest friend that she was only likely to live for another week or so.

They were keen to go home, but the next day Mark rang me in a very distressed state, unable to cope with her dyspnoea. I readmitted her, and with a subcutaneous infusion of opioids and benzodiazepines, she died peacefully in the presence of her family the next day. I spent a very emotional hour with Mark, Diane and the children, in Diane's hospital room after she died. I cannot adequately describe the emotional mixture of love, grief, relief, responsibility and privilege I felt at that time.

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In the interest of brevity, I have given a brief outline only, omitting most of the finer clinical management details. I would, however, like to comment on aspects of this dual role of doctor and friend.

1. OBJECTIVITY/CLINICAL JUDGEMENT

In theory, we treat our friends and family as we would anyone else. In practice this is not always the case. I wanted Diane's progress to be asymptomatic, and I found myself being more distressed with her symptoms than I normally would be. This may seem an obvious statement, but over the 18 month period I think this did affect my judgement. There were occasions when I hastily reacted to symptoms, when the more prudent approach would have been further observation. This was highlighted during a weekend when I was away, and I did not delegate her care to anyone else, and managed her escalating pain by telephone. A distressing delirium was the result, which I believe would have been avoided had I not been so reluctant to delegate. Management of her last few days, when she developed respiratory failure was also difficult in terms of judging sedation doses, etc. Simple procedures such as venesection and IV cannulation for blood transfusion became very distressing due to chemotherapy ravaged veins, and her acquired phobia for needles. My usual 'compassionate detachment' during these difficult cannulations was severely challenged.

2. THE RELATIONSHIP

General Practitioners constantly deal with the issue of treating friends, especially in a rural setting. Friendships do change, and in some ways become stronger as a result of this. Managing a friend's terminal illness significantly alters the relationship, especially considering the counselling and support given to the entire family. I found myself feeling uneasy if I was away and unavailable for a day, and planning days away was always tempered with the thought of Diane's possible needs on that day. Diane initially expressed a concern about becoming vulnerable and dependant within our relationship, but was aware that this would be unavoidable to a degree. Golf games with Mark were never quite the same, once I began looking after Diane. In general conversation I found it harder to complain about aspects of my work (as was my previous habit!). On the other hand, the relationship with Diane and Mark went to a deeper, richer level, and will continue with Mark in the future.

3. INTERPRETATION

An important role for a General Practitioner is to help patients through the maze of specialist appointments, especially during the difficult to define transition between curative, hopeful treatments into the palliative phase of their illness. Interpreting specialist's comments, 'reading between the lines', and

providing 'big picture' context to specialist's decisions are a very important part of our work. I am sure that most specialists would not understand just how much of this we do, nor how important this is for our patients. Diane was fortunate to have specialists who were supportive, compassionate, and good communicators, but still there was much work to be done after appointments to help them understand what was happening. Being such a close friend led to many evenings when I found myself reinforcing the bad news of the latest scan etc. This was very draining and quite distressing.

4. CONFIDENTIALITY

Diane was extremely well known in our town. Many people, reluctant to visit for fear of being intrusive, or unsure about what to say, would ask me about Diane's progress. This would be at the shopping centre, the football club etc. Not only did this present difficulties from a confidentiality point of view, but also kept Diane's situation prominent in my mind. This again, will sound familiar to all GPs.

5. SUPPORT

A very positive aspect of Diane's care from my personal point of view was the support I received from many areas. The local hospital staff was very aware of my relationship to Diane, and was incredibly supportive. Small things such as having a coffee ready for me after seeing her in hospital etc were very helpful. Many of the nursing staff were also friends with Diane, and the entire episode, with mutual support, was very unifying. Some of my Palliative Care colleagues in Adelaide were aware of my situation, and offered support, both before and after Diane died. Fortunately, her course was reasonably straight forward from a palliative medical aspect, but I remain very grateful and feel supported by those colleagues. Finally I was supported by my community. Many people knew how close I was to Diane, and expressed support and concern for me during Diane's illness, and after her death.

In summary, looking after Diane was probably the hardest clinical and personal challenge I have had in 20 years of General Practice. Many aspects of the unique challenge of Palliative Care in rural General Practice were taken to an extra level as a result of the close personal relationship. I have been both enriched and traumatised by the experience, and have felt an increased level of community support as a result. The pitfalls, difficulties and stress combined with the sense of satisfaction and privilege associated with looking after such a close friend give further relevance to the phrase I often use to describe Palliative Care in rural General Practice: -

"Great reward at great cost"

Dr Graham Hughes
General Practitioner, Mt Barker, SA
ghughes@healthon-net.com

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making the most of life

DIRECTOR OF PALLIATIVE CARE, MARY POTTER HOSPICE, WELLINGTON, NEW ZEALAND

Exciting professional opportunity and enviable lifestyle in the South Pacific

Applications are invited for the full-time Director of Palliative Care at Mary Potter Hospice, Wellington, New Zealand. This position has become available due to the incumbent being appointed as the Inaugural South Link Health Chair in Palliative Care at the Dunedin School of Medicine, Otago University.

Mary Potter Hospice is a leading provider of Specialist Palliative Care with a strong commitment to clinical excellence, education and research. Mary Potter Hospice encompasses the largest in-patient unit in New Zealand and three regional services within our community. The Director of Palliative Care has a significant role in maintaining and extending professional leadership within the Hospice and its community, and promoting excellence in palliative care throughout New Zealand and internationally.

The Director of Palliative Care reports to the CEO and is responsible for the management of education, research & quality improvement and will contribute to the strategic development of the services as a member of the Executive team. We are looking for a very experienced specialist in palliative medicine with strengths in motivating and leading others.

In addition to an excellent professional opportunity the position comes complete with an enviable lifestyle in Wellington, the capital of New Zealand and creative centre of Lord of the Rings. The sun shines, the grass is literally greener and the harbour unsurpassed. More cafes per capita than New York, nature and sports facilities to rival the world's best, internationally renowned arts and culture.

For a role description please contact Maria-Goretti Sialava'a at Mary Potter Hospice, Wellington, New Zealand, on (04) 389 5018 extn 850 or by email to maria-goretti.sialavaa@marypotter.org.nz

Applications, including your Curriculum Vitae and a covering letter, will be accepted until 5.00pm Friday 18 July 2003.

PALLIATIVE SPECIALIST IN SINGAPORE

Assisi Home & Hospice (AHH) in Singapore is looking for a resident Palliative Specialist. There is a considerable lack of doctors specialising in palliative medicine in Singapore and we are looking overseas to remedy our situation.

AHH is a Voluntary Work Organization with 35 beds, set up by the Franciscan Missionaries of the Divine Motherhood Sisters (FMDM) in 1969. The hospice provides 3 different services i.e. In-patient care, Home Care, Day Care for adult and children. Cancer patients of all races, religion and values are welcome. Here at AHH the patients together with the team of nurses, doctors, medical social workers and pastoral care sisters work towards finding hope, wholeness, reconciliation, harmony and peace within themselves. We work to ensure that our patients live their lives to the fullest. You can visit www.assisihospice.org for more information on the hospice.

We are presently depending on locum doctors; we are therefore looking for doctors who are willing to relocate to Singapore to practice. They need not be Catholics or Christians by faith. However, all applicants for the position must meet requirements for registration with the Singapore Medical Council before they can practice. You can visit <http://app.moh.gov.sg/sea/sea0319.asp> to check on the minimum qualifications required for registration.

If you are practicing palliative medicine now and would like the opportunity to work in Singapore, you are welcome to write or call us. If you are interested in palliative medicine and would like to specialise and practice in Singapore, we are prepared to send you for the necessary training. You can call or write to discuss this.

Contact Person: Ms. Sally Tan (Administrator) Contact telephone number: (65) 63476446

Contact email: sally_tan@mtalverniahospital.org