Volume 10 Issue 2, October 2001

ANZSPM

newsletter

ANZSPM
Australian and New Zealand Society of Palliative Medicine

Send Articles to: The Editor, ANZSPM Newsletter,
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if you prefer fax to: 08 8277 4957
Or use the web site: www.anzspm.org.au

EDITORIAL

I hope you find this edition of the Newsletter of interest.

ANZSPM is at a crucial time in its history. The challenge is to represent all doctors caring for patients facing the end of life. We are grappling with our mission and forging links with associated professional bodies. We need collaborative relationships locally with our colleagues but also need to develop similar links at a more formal organisational level as well.

I am delighted to publish debate about the Position Statement on Palliative Care/Medicine and our relationship with other professional bodies.

There are announcements of coming conferences and reports of several recent meetings and a summary of the recent AGM in Hobart. A full report is on the website.

Read about the Asia Pacific Hospice Palliative Care Network. ANZSPM is an organisational member. There is a great need to support countries in our region in developing culturally appropriate palliative care within their own context.

There is a preliminary report from the Joint Committee of PCA, COSA and ANZSPM. That daunting questionnaire you all completed has already produced important information and been of value in discussions with Federal and State politicians and bureaucrats.

There are several classifieds about further education opportunities and employment.

And finally, we should try to remember that it is better to try to be happy.

"The surly bird catches the germ."

Best wishes

Greg Crawford
Adelaide
October 2001

PRESIDENT'S SOAPBOX

A week can be a long time. Who could have imagined the changes that would unfold during the week that many of us were away from home and in Hobart? The PCA Conference took place in the shadow of the calamitous terrorist attack in the US and the subsequent collapse of Ansett, which had a more immediate practical impact on many delegates.

Perhaps the best analogy that I can relate to is that of a fit young person who thought that they controlled their world and expected to live to a ripe old age, discovering that they had a serious and life threatening illness. Their dreams are under threat and they can feel very insecure. This instability and uncertainty is something that many of us felt and has been manifest in our desire to get home to our families and back to our core roles and responsibilities.

The Conference itself was a great success and a credit to Paul Dunne and his team. We were provided with the usual range of networking opportunities and exposure to the full gamut of our colleagues in palliative care. A number of doctors observed that they would have liked a greater medical component to the programme. If I can take the liberty of a bit of advertising, that will be one of the aims for Conference 2002 in Townsville next year. A report on the content of the PCA Conference is to be found elsewhere in the Newsletter.

I was interested to see a paper presented on the move to create a role for palliative care nurse practitioners in an urban area. From informal discussion with the presenters of the paper it seems to me that this move stems in part from the frustration that nurses were feeling with inadequate medical support for their patients in the community. We all know the variety of reasons why this might be the case. I told the nurses that I felt this project could be sending the wrong message to GPs who might feel their role further undermined or, in some cases, would claim to be absolved of their responsibility. The nurse's understandable and predictable response is that they are filling a need. Nature abhors a vacuum.

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I hope that the Joint Position Statement on the Role of GPs in Palliative Care will provide encouragement for GPs to take on greater involvement in palliative care, now expected of them by their Colleges. However the words are meaningless without the resources to make serving these patients economically viable. Those of us in specialist practice must recognise the need for GPs to be appropriately supported and funded. Patients need enthusiastic, well-trained and adequately remunerated doctors to fulfill their need for palliative medicine.

Another consequence of the distressing events of last week has been to lead us to re-examine our lives and the activities that we undertake. I think that we can all consider which of other people's hoops we might refuse to jump through. I will end this Soapbox with the final paragraph of my President's Report which was written several weeks ago and delivered at the AGM in Hobart.

"I would like to close with some observations on the direction of health care systems and their impact on all our lives. Recently I have observed quite a number of highly committed clinicians (including me) who at times feel overwhelmed, not by their clinical duties which they enjoy greatly, but by lack of resources, the ceaseless demands of documentation, accreditation, so called quality improvement and bureaucracy. Sometimes it is important to ask how these processes improve patient care rather than fulfill some temporary fad of a management theory. Are they always an appropriate use of limited resources including time? As a Society, and as individuals, we must be careful to take on projects that improve patient care and enhance the ability of our members to provide it. We can only manage the tasks for which we have the resources and energy, and at the pace we can all manage. If there is one lesson that we should all have learned from our work in palliative medicine it is of the need to maintain the quality of our own lives. Life is a marathon, not a sprint If we are to be sustained in the work that we enjoy, we must maintain the balance in our own lives that we advise for our patients. Take your holidays, get a hammock, daydream! No one is so indispensable that we can do without them for the long haul."

Will Cairns
Townsville

LETTERS TO THE EDITOR

Dear Editor,

Glancing through the May/June issue of the newsletter I come across the joint position statement on palliative medicine in general practice which goes on to say "palliative care is specialised health care of dying people".

A few pages later we have the draft position paper on the practice of palliative medicine and palliative care. I do not think that I am the only person that gets confused between palliative care and palliative medicine and the joint position statement in general practice starts off by saying it is a position statement on palliative medicine and then goes on to specifically address palliative care. As one who is perhaps considered to be on the fringe on the palliative medicine/care systems I get a little bit concerned about these confusing terms. I have no doubt that our patients have no idea what the difference is and I do not imagine most doctors do and I imagine the terms are almost interchangeable to most. The draft position paper on the practice of palliative medicine and palliative care does go some way to explain that and, therefore, I suppose it is helpful.

I do feel however my main concern is that the statement on palliative care emphasises so much the care of "dying" people. I know that there has perhaps been too little attention to those aspects of our care of patients which involve their deaths. In attempting to right that I believe there is an over emphasis now on the care of the dying as part of the practice of palliative medicine and indeed palliative care.

Palliation covers a wide variety of symptoms and therefore many modalities of treatment. Sadly I do not see the ANZSPM, the Chapter of Palliative Medicine or Palliative Care Australia entering into dialogues with the oncology specialties when it comes to the appropriate review of our palliative care services for patients with cancer.

I would like to open up the debate on these two issues - are we not over emphasising the care of the dying to the detriment of the whole spectrum of palliative care; and are we not somewhat forgetting the other players at least in the palliation of cancer symptoms?

Yours faithfully,

Professor Alan Rodger
Director of Radiation Oncology
William Buckland Radiotherapy Centre
Melbourne

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Dear Editor,

I commend Will Cairns on his draft Position Paper on the Practice of Palliative Medicine and Palliative Care.

This is an important document. I would make two comments

(i) the secret of a Position Paper we wish to distribute to our colleagues is that it is short and clear, and

(ii) that the Position Paper be focused directly on Palliative Medicine and Palliative Care.

ANZSPM is (or should be) a pro-Palliative Care organisation, not an anti-euthanasia one. If ANZSPM wants to produce a position paper on euthanasia or existential distress or anything else, fine; but don't blur the primary Position Paper with those discussions.

I would suggest something along these lines:

Palliative Care is the care of patients with active, progressive, far-advanced disease and a short life expectancy, for whom the focus of care is relief and prevention of suffering and quality of life.

Palliative Care is holistic in approach and aims to address all aspects of a patient's suffering including pain and physical symptoms, psychological problems, social difficulties, cultural concerns and matters of spiritual or existential distress. Palliative Care is usually practiced by a multidisciplinary team including doctors, nurses and allied health personnel to cover all aspects of care. Palliative Care includes support for family members both during the illness and bereavement.

Palliative Care is person-orientated, not disease-orientated, and the focus is on the quality of life. Palliative Care is not primarily concerned with life prolongation, nor life shortening. Palliative Care supports the rights of patients to make informed decisions about their medical care. Palliative Care can be practiced in all venues of care - home, nursing home, hospice and hospital - and, whenever feasible, the choice of the site of care is made by patients and their families.

The principles and practice of Palliative Care should be initiated when patients are symptomatic of an active, progressive, far-advanced disease and should never be withheld until all avenues of treatment of the underlying disease are exhausted or further active medical treatment considered inappropriate. Palliative Care, particularly psychosocial care, is complementary to active treatment of the underlying disease and should be integrated in a seamless manner with it. The goal of Palliative Care is that whatever the disease, however advanced it is, whatever treatments have already been given, there is always something that can be done to improve the quality of the life remaining to the patient.

Roger Woodruff
Director of Palliative Care
Austin & Repatriation Medical Centre
Melbourne

Dear Editor

As a new member of ANZSPM, can I use your newsletter to ask for especially GP input into rural and regional cancer care planning.

Initially proposed by Eric Fairbank, I have been asked to join the interim executive of a new group within COSA, for outside metropolitan areas. Also on this is our esteemed president Will Cairns, and medical and radiation oncologists, surgeons, nurses and consumer reps, covering hopefully all States and Territories.

The proposed aims at present are to look especially at access to oncology services, education issues for rural health professionals and communication pathways.

There will be a meeting at the COSA conference in Brisbane 28 - 30 November 2001.

As most rural GPs involved in palliative care also do a lot of general cancer care I thought ANZPM may be a good way to get in touch with people.

I would greatly appreciate any input especially from rural and regional GPs and would be happy to let people know what is developing, either individually or as a group. This may prove to be a useful forum.

I will also contact ACCRM and the rural faculty of the RACGP.

Any other suggestions?

Sue Robertson FRACGP
Hamilton Medical Group, Victoria
e-mail: Dr.Sue.Robertson@wdhs.net

ANZSPM WEBSITE

www.anzspm.org.au

Go there today. Check your contact details are correct. You will need your password. Print a report of your State or country's members.

Are there doctors interested in Palliative Care who are not there? Do they know about ANZSPM? Why not talk to them today.

ANZSPM – the special society for ALL doctors with an interest in Palliative Medicine.

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CONFERENCE REPORTS

6th Australian Palliative Care Conference, 11th-14th September 2001, Hobart
A General Practitioner's perspective

It is hard to summarise or even focus on the recent Palliative Care Australia conference without thinking of the dreadful world events which occurred just hours prior to the first session. It was a week when I am sure a lot of us would rather have been home with our families.

Nevertheless, congratulations need to be extended to Paul Dunne and his fellow organisers who put together a conference covering a wide range of topics, with particular focus on Motor Neurone Disease, Communication, Paediatrics, and Indigenous needs. I also congratulate Paul for his sensitive handling of the opening address, incorporating a minute silence for the catastrophe in New York, which was unfolding as the conference began.

Keynote speakers illustrated the themes of the conference, starting with Dr David Oliver delivering a comprehensive overview of Motor Neurone Disease, with particular reference to palliative care needs. Prof Lesley Fallowfield presented a challenging look at communication deficits between medical staff and patients/carers. Prof Danai Papadatou, talking about the grieving process of Health Professionals after childhood death, took up the paediatric focus. Prof Michael Ashby presented his overview of Palliative Care, its development, and current position within the Medical community. We were challenged to take to the keyboard and write reflectively about our experiences with death and loss by Prof Allan Kellehear. More clinically oriented addressed were delivered by Prof Alan Rodger, discussing the integration of radiotherapy into symptom control, and Prof Michael Cousins, who gave an overview of pain, and introduced the concept of pain as a separate disease entity.

The communication theme was highlighted by Brigit Hogan, who delivered the inaugural Ian Maddocks lecture, titled "When words fail, music begins" This was a fascinating description of her phenomenological study of patient's experience of music therapy. Her presentation was one of the highlights of the meeting.

Comic relief for the week was provided by "Eddie McThorne" and his "colleagues" who looked at Palliative Care standards through the quiz show, "Who wants to be a squillionaire". Concurrent sessions covered a wide range of topics, and as is often the case, choosing between sessions was difficult.

Maintaining a working interest within a busy semirural practice is not always easy (to say the least!), so the conference was useful for 2 main reasons. Firstly, the interesting presentations helped "keep the fire burning". Secondly, it was good to renew friendships, (and make new ones), in an atmosphere of warm Tasmanian hospitality. The social aspect of the conference was excellent, which was helpful during such a traumatic week.

I was, however, disappointed in the lack of new clinical content, particularly related to General Practice. The vast majority of conference delegates would be working in, or closely associated with, specialist palliative care units and tertiary hospitals. Most people who die, however, do so in the care of a palliative care "team" which consists of the family, GP and community nurse.

The role of the GP, and the invaluable pre-existing relationship between the patient and the GP, was overlooked in many of the presentations. I was particularly disappointed that a keynote speaker discussing communication difficulties made no reference to the GP at all. It is, in fact, the GP who helps the patient through the transitions between diagnosis, treatment, palliation and ongoing bereavement support. The GP fills the communication gaps, and is very often the best "communicator" throughout the journey. This was simply not recognised at this conference, and a few presentations I attended actually discouraged GP involvement.

I think ANZSPM has a significant role in encouraging and empowering GPs in Palliative Care. The formation of the Chapter (which I fully support) runs the risk of alienating GPs who have a passion for Palliative Care. This will particularly be so when the majority of specialists will come through physician training programmes, with no experience in General Practice. The overall improvement of the delivery of palliative care in this country depends largely on up-skilling and supporting GPs and community nurses. It is my hope that ANZSPM can support this view, in addition to its role in maintaining excellence and support in specialist practice.

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Conferences in Palliative Care can be draining and, at times, emotional. This meeting, of course, was compounded by the events in New York. I, like everyone else, was looking forward to returning home. To wake up on the last day to discover that Ansett had fallen over, thus stranding me in Hobart was just another drama in a week best described as surreal! The Ansett drama gave me an extra day to visit Port Arthur.

A 3 day conference on death and dying, carnage in New York, an airline collapse and a day at Port Arthur certainly gave the conference theme, "Learning to Live" a striking relevance. I enjoyed the week, but I have never been happier to arrive home to my wife and kids! Congratulations and thanks to all involved in organising and presenting.

Graham Hughes
General Practitioner
Mt. Barker
South Australia

The International Union of Physiological Sciences Satellite Symposium on Pain Mechanisms

I attended the symposium at The Australian Museum in Sydney during August. Unlike other pain and palliative care meetings there were only about 50-100 registrants. While most were pain physiologists, there were several physicians representing pain, rehabilitation and palliative care interests. The symposium was organised simply into morning and afternoon plenary sessions, which allowed the whole group to focus on the topics of the session.

The five sessions were:

a) Receptors and Channels
b) Mechanisms of inflammatory and neuropathic pain
c) Pain modulation - Pharmacology
d) Pain modulation - Cognition, attention and central mechanisms
e) Pain and the cortex

A few highlights that I encountered were: -

Andy Dray from Canada presented an interesting plenary on current and potential molecular targets for analgesia, including G-protein coupled receptors, voltage and ligand gated ion channels protein kinases and gene transcription regulators. All this in simple English!

Julia Flemming from Melbourne discussed 'Paradoxes presented by the clinical use of lignocaine for neuropathic pain: old drug new mechanisms?' Julia was the first clinician to talk at any of the plenaries and introduced the complexities of pain that patients present with. It was an interesting contrast to move from the realms of basic science into the uncertain world of clinical pain. Many of the basic scientists were fascinated by the difficulty with pain assessments or treatments, and the associated pathophysiological or pharmacological explanations for them.

Maree Smith from Brisbane talking about 'Heterodimeric opioid receptors: novel targets for a new generation of opioid analgesics'. Maree discussed the molecular biology of opioid receptors subtypes and identification of a receptor containing both (and (1 opioid receptors. This discovery could account for the differences that are observed in the potency of different opioids, or the concurrent use of more than one opioid.

The organisers did a remarkable job with this intimate symposium, keeping discussions to time, food a plenty and managing to keep this clinician interested. No ZZZZ breaks, no truancy and no nonsense!

Guy Bannink
Staff Specialist in Palliative Care
Royal Adelaide Hospital

COMING EVENTS

CLINICAL ONCOLOGICAL SOCIETY OF AUSTRALIA MEETING

28th Annual Scientific Meeting
Brisbane Exhibition & Convention Centre
28-30 November 2001

Further information from
COSA Secretariat
Ph. 02 9380 9022 Fax. 02 9380 9033

2002 ANZSPM SCIENTIFIC MEETING

Townsville
25-28 September 2002

Keynote speakers include Dr Ann Goldman, Paediatric Palliative Care Specialist from Gt Ormond Street and Dr Peter Maguire, Psychiatrist from Manchester

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ANNUAL GENERAL MEETING

Summary of the Annual General Meeting, 13th of September 2001, Hotel Grand Chancellor, Hobart

President's Annual Report (Will Cairns)

ANZSPM has undertaken a range of activities aimed at enhancing the ability of medical practitioners in all areas of health care to provide high quality palliative medicine for their patients.

The Joint Position Statement on the Role of General Practitioners in Palliative Care was initiated by ANZSPM and has been approved by all three GP colleges; RACGP, RNZCGP and ACRRM.

There have been discussions and research into how you or your GP colleagues might best be helped to practice palliative medicine in the community. Among the possibilities are a variety of courses or perhaps some form of certification similar to the Diploma of Obstetrics. Your responses and those of the GP colleges will guide the next step.

Now it is time to enhance our relationships with the various specialist groups who treat the vast majority of patients referred to specialist palliative care services. It may be that this process would best be undertaken in conjunction with the Chapter of Palliative Medicine, although we must be careful to recognise the differences between our membership. This process has only just begun and I hope to be able to report more to you in the ANZSPM Newsletter and at the AGM next year.

In Australia the Joint Therapeutics Committee of ANZSPM, PCA and COSA, under the Chairmanship of Peter Ravenscroft, continues to address the vexed question of how patients can obtain easier ready access to a range of commonly used medications. (See preliminary report on page 9.)

We remain an affiliate member of Palliative Care Australia. We have been represented at all the face to face council meetings of PCA for a number of years and are thus able to participate in debates as they take place and voice the perspective of medical practitioners. Of particular interest to us are the development of models of care, standards, funding for research, clinical databases and the role of PCA in the political debate with particular reference to the upcoming federal election.

ANZSPM is recognised by the RACP as the special society representing the interested of palliative medicine to the College. The biannual meetings of the Specialties Board of the College include a rather heterogeneous mixture of groups ranging from physician only bodies such as the neurologists, to those which include many non medical members, such as the Cardiac Society. They provide an opportunity for the College to describe its activities as they relate to the practice of the various sub-specialties, and for the special societies to communicate specific issues for them.

Perhaps of most immediate relevance to us are the activities of the Health Policy Unit of the RACP which, at our prompting, is to embark on a project looking at decision making in the latter stages of life. Of particular interest is the appropriateness of intrusive and often expensive interventions that do not bring any benefit in terms of quality at the end of life.

In March I went to the ANZSPM NZ Annual Conference on Waiheke Island off Auckland.

Last year's Conference 2000 in Geelong was a great success thanks to the work of Trevor Banks and the Geelong Division of General Practice.

Planning is well underway for Conference 2002 in Townsville, September 25-28th. I hope that you will all make an effort to attend.

Obviously there are a wide range of activities that ANZSPM could undertake. At our Council meeting in August we discussed the need to review the activities that we are undertaking as a Society, and to assess how they meet the Objects expressed in our Constitution. We would like to be guided by you and hope to hear from you. We can then work out our priorities for the next year.

It is important at this time to thank the Council for their willing participation in the burdensome duties of office.

Next year sees another election for the President and Council of ANZSPM. I hope that you the members will consider how you might participate in the ongoing work of our Society. At our last Council meeting we observed that the Council was made up exclusively of those practicing full time in palliative medicine. I will not re-nominate for President as I feel that regular change is necessary for the ongoing development of ANZSPM and the practice of palliative medicine.

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Life is a marathon, not a sprint. If we are to be sustained in the work that we enjoy, we must maintain the balance in our own lives that we advise for our patients. Take your holidays, get a hammock, daydream! No one is so indispensable that we can do without them for the long haul.

ANZSPM has 272 members.
Current surplus of $A44,282.27, current assets of $A47,432.53 and current liabilities of $A3,150.26

New Zealand Branch Report (Anne MacLennan)
The Chapter of Palliative Medicine was accepted in law as a vocational (specialty) group in NZ on 7th September. Fellows of the Chapter can now apply for Vocational Registration in Palliative Medicine, ie specialist status.

The National Palliative Care Strategy was launched in February 2001. The strategy "seeks to ensure that people who are dying and their family/whanau who could benefit from palliative care have timely access to quality palliative care services, that are culturally appropriate and are provided in a co-ordinated way".

The discussion document defined four essential services to be publicly funded:

a) multidisciplinary assessment
b) care co-ordination
c) clinical care
d) support care

There is a recommendation for organising through regional specialist palliative centres, with responsibility for providing specialist PC and ensuring appropriate local PC providers throughout the region. The importance of hospital PC was recognised and formation of hospital palliative care teams in all tertiary hospitals is recommended. The need for PC for people with diseases other than cancer was acknowledged.

The NZ health service has embarked on yet another structural change with 21 District Health Boards being set up for local management of health services. These DHBs are to ensure provision and to purchase the local palliative care services.

At the time of publication of the Strategy, there were 147 designated PC beds in NZ - 15 inpatient hospices, 14 community-based and 11 hospice support/outreach services. It is estimated that hospices care for 6,600 patients annually. In 1996, there were over 28,000 deaths (approx 7,500 cancer).

There has been increasing concern about access to, or funding for, certain drugs indicated for evidence-based good practice in palliative care. These drugs include fentanyl, octreotide, gabapentin and ketamine. The NZ branch of ANZSPM decided at our annual meeting in March, to set up a Pharmaceutical Access Group to work on the problem. Around the same time, the Ministry of Health set up a Cancer Treatment Working Party with four subgroups, including palliative care. There were some common aims. So far, neither group has made much progress, but with collaboration between the two groups, we expect to develop the issues relating to palliative care later this year.

ANZSPM has been accepted in principle as a member of the NZ Specialties Board of the RACP.

The ANZSPM conference in 2004 is to be in Auckland. It is proposed that the ANZSPM meeting will back on to the biennial Hospice NZ conference.

Current executive
Anne MacLennan, Wellington - chairperson. aomacl@ihug.co.nz

Carol McAllum, Auckland - secretary cmcallum@ihug.co.nz

Brian Ensor, Auckland - treasurer briane@nshospice.co.nz

Julia Holyoake, Christchurch -jholyoake@clear.net.nz

There are 53 paid-up members. Not all Chapter Fellows are ANZSPM members.

Subcommittee Reports
As Chairperson of the Therapeutics Subcommittee, Peter Ravenscroft reported on the good progress of the Joint Therapeutics Committee of ANZSPM, COSA and PCA. (See report on Page 9.)

Date and Place of Next Annual General Meeting
Townsville, 26th or 27th of September 2002.

NEW MEMBERS

Welcome to the following new members

Dr Justin Beilby	SA
Dr Andrew Broadbent	NSW
Dr Stephanie Cooper	SA
Dr Louise Elliot	NSW
Dr Lynne Kuwahata	NSW
Dr Philip Lee	NSW
Dr Rita Malik	WA
Dr John Pakos	SA
Dr Susan Robertson	VIC
Dr Ram Seshadri	SA

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THE ASIA PACIFIC HOSPICE PALLIATIVE CARE NETWORK

The Asia Pacific Hospice Palliative Care Network is a new organisation that has been established to link persons working to develop hospice and palliative care programs in Asia and the Pacific.

OBJECTIVES of the ASIA PACIFIC HOSPICE PALLIATIVE CARE NETWORK

* To facilitate the development of hospice and palliative care programs
* To promote professional and public education in palliative care
* To enhance communication and dissemination of information among members
* To foster research and collaborative activities
* To encourage co-operation with other relevant professional and public organisations.

MEMBERSHIP BENEFITS

All members will receive the following benefits:

* Receive news updates on APHN and developments in the region
* Request for teaching and resource materials on palliative care
* Request for teaching faculty to visit their program
* Obtain access to members' section of the web site
* Employment opportunities
* Courses and clinical attachments.

TYPES OF MEMBERS & RIGHTS AND RESPONSIBLITIES OF MEMBERSHIP

Individual Members

Persons who are actively involved in all or any aspects of hospice palliative care are eligible to be Individual Members.

* Pay designated subscription fee
* Be appointed, elected or co-opted to the Council
* Nominate candidates for election to Council
* Attend General Meetings
* Cannot vote at General Meetings

Ordinary Organisational Members

Organisations that have demonstrated a commitment to the practice, education or administration of hospice palliative care programs are eligible to be Ordinary Organisational Members.

* Pay designated subscription fee
* Nominate candidates for election to Council
* Representative to attend General Meetings
* Representative can vote at General Meetings

MEMBERSHIP SUBSCRIPTION FEES

Rates are on a sliding scale according to the income of individuals or the operating expenditure of organisations. Calculation of the fee is to be made by individuals or organisations when applying for membership.

APPLICATION FOR MEMBERSHIP

All applications are to be made on the Application Form. The APHN Constitution requires that all applicants agree to uphold the values of APHN.

The Values of APHN

* We respect every individual, regardless of sex, age, race, intellectual or socio-economic standing.
* We value every moment of life and will not support any action that has the intention of shortening a person's life.
* We recognise that the individual and the family are entitled to make informed decisions about care.
* We respect the confidentiality of all information arising out of the provision of care.
* We believe in empowerment of the individual, the family and the community.
* We respect the faith, belief system and culture of each individual.
* We respect the rule of law and will work within the law of each country.

SECRETARIAT

Dr Rosalie Shaw, Executive Director, Asia Pacific Hospice Palliative Care Network

Department of Palliative Medicine, NCCS, 11 Hospital Drive, Singapore 169610

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NATIONAL SURVEY OF ESSENTIAL MEDICATIONS IN PALLIATIVE CARE

Report from the Joint Therapeutics Committee - Palliative Care Australia (PCA), Clinical Oncological Society of Australia (COSA), Australian and New Zealand Society of Palliative Care.

This is a short report to bring members up to date about this survey conducted at the end of 2000 following the Geelong Conference. The response rate of 100 returned questionnaires was approx 35%. We are still receiving the occasional one! Preliminary data is available and the final detailed report will be provided by the end of the year. The mean age of respondents was 46 yrs and the male:female ratio was 60:40. The mean number of years since graduation was 23. Fifty-two percent of the respondents listed Palliative Medicine as their main area of clinical practice. The following table provides information on the 5 top medications for each of the 25 symptoms in the questionnaire.

Symptom	Medications in order or response
Pain - Analgesics	morphine, fentanyl, oxycodone, methadone, hydromorphine
Pain - Non Opioid Analgesics	paracetamol, celecoxib, naproxen, aspirin, tramadol
Pain - Adjuvant Analgesics	amitriptyline, valproate, dexamethasone, gabapentin, carbamazepine
Dyspnoea	morphine, midazolam, dexamethasone, lorazepam, salbutamol
Cough	morphine, codeine, lignocaine, pholcodine, dexamethasone
End Stage Respiratory Reflexes	hyoscine hydrobromide, atropine, glycopyrrolate, midazolam, hyoscine butylbromide
Terminal Restlessness	midazolam, clonazepam, haloperidol, phenobarbitone, chlorpromazine
Anorexia	dexamethasone, megestrol acetate, prednisone/prednisolone, metoclopramide, medroxyprogesterone
Nausea	metoclopramide, haloperidol, cyclizine, ondansetron, dexamethasone
Vomiting	metoclopramide, haloperidol, ondansetron, cyclizine, octreotide, prochlorperazine
Dysphagia	dexamethasone, cisapride, nystatin, metoclopramide, fluconazole
Hiccup	chlorpromazine, metoclopramide, baclofen, nifedipine, haloperidol
Dyspepsia	omeprazole, ranitidine, aluminium hydroxide, cisapride, misoprostol
Constipation	docusate with senna, lactulose, bisacodyl, docusate, senna
Ascites	spironolactone, frusemide, octreotide, dexamethasone, bumetanide
Oral Ulceration	lignocaine (viscous), nystatin, benzydamine, aciclovir, fluconazole
Dry Mouth	artificial saliva, pilocarpine, nystatin, sodium bicarbonate, saline
Delirium	haloperidol, midazolam, chlorpromazine, clonazepam, risperidone
Depression	sertraline, amitriptyline, moclobemide, paroxetine, fluoxetine
Insomnia	temazepam, flunitrazepam, clonazepam, nitrazepam, oxazepam
Anxiety	diazepam, lorazepam, oxazepam, midazolam, alprazolam, clonazepam

This is early data and the committee plans to process this further with data splitting on main area of medical practice, age and sex. In addition it is obvious we are relatively unfamiliar with the levels of evidence supporting our clinical practice of Palliative Medicine. This is an area, which may guide our future research efforts as well as educational initiatives. The data obtained from the dose questions was generally not very useful. The essential/desirable data is still to be analysed. The Committee has already made some use of the raw data in submissions with the PBAC in July.

John Cavenagh (on behalf of the Joint Therapeutics Committee)

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CLASSIFIEDS

Flinders University
Adelaide - Australia

DEPARTMENT OF PALLIATIVE CARE

POSTGRADUATE MULTIDISCIPLINARY AWARDS IN PALLIATIVE CARE

Offered by Distance

Graduate Certificate in Health (Palliative Care)
(1 year part time)

Graduate Diploma in Palliative Care
(2 years part time)

Master of Palliative Care
(3 years part time)

Master of Science (Palliative Care)
(4 years part time)

For more information please contact

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ANZSPM newsletter

CLASSIFIEDS

CENTRE FOR PALLIATIVE CARE

POSTGRADUATE CERTIFICATE IN PALLIATIVE MEDICINE

The one-year Postgraduate Certificate and two-year Postgraduate Diploma courses are aimed at both medical practitioners who wish to train and specialise in Palliative Medicine, and general practitioners who seek to enhance their knowledge and expertise in this field.

Students undertaking the Diploma course study four subjects, including:

* Clinical Symptom Management (Certificate/Diploma courses)

* Psycho-Oncology (Certificate/Diploma courses)

* Culture and Ethics (Diploma)

* Advanced Disease (Diploma)

For both courses, the Australasian student fee in 2002 is $1,850.00 per semester.

A weekly lecture-seminar program is conducted for students from metropolitan Melbourne, and a Distance Learning programme is available for rural, interstate and overseas students. GPs gain full 3-year CME points from the Postgraduate Diploma.

Applications close: 30th November 2001
LATE APPLICATIONS WILL BE ACCEPTED.

For a course handbook and/or applications forms, please contact

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THE UNIVERSITY OF MELBOURNE

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ANZSPM

newsletter

RESULTS OF SURVEY ABOUT GP QUALIFICATIONS IN PALLIATIVE CARE

The results of the survey we undertook to obtain your feelings about training were disappointing in that only 40 members replied, representing only about 15% of our membership. Furthermore, about half of these replies were from those other than GPs.

Only six replies were received from members who identified themselves as GPs not working in the area at present. Two of these four members felt that the lack of a postgraduate qualification currently limited or might limit their practice in the area, four did not.

Fifteen replies were received from members identifying themselves as GPs currently working in the area. Many of these respondents commented that they had or were currently involved in training. Four members wrote detailed letters expressing their unhappiness with the process of Chapter intake, one suggesting consideration of a review and second Grandfather intake. This group of members overwhelmingly stated that lack of qualifications was not currently limiting their practice, they were afraid that it would in the future. These members were evenly distributed in their interest in various forms of postgraduate training.

Seventeen replies were received from those other than GPs with two expressing concern that they may be limited by lack of qualifications in the future, and once again evenly divided in the kind of postgraduate activity they felt appropriate for themselves or others. There were no comments from this group in relation to Chapter entry.

Two replies were unidentified.

I feel the small numbers prevent any strong conclusions being drawn from the survey in relation to the most appropriate form of postgraduate education, as four members suggested each of:

1. Formal tertiary qualification

2. Diploma

3. Less formal qualification

4. Summer Schools.

There are clearly a number of GPs out there in part time palliative medicine who are unhappy about the process of Chapter entry.

Your Council would be pleased to hear further feedback in relation to this and other training related issues. We will continue to discuss the needs of GPs in this area. Will Cairns was recently in Sydney at the RACGP AGM, and has discussed these issues there. The Council will continue to communicate with the Chapter on behalf of the membership.

Sincerely,

David Brumley
Ballarat, Victoria

JOB VACANCY

PALLIATIVE MEDICINE SPECIALIST
Part Time Position - 20 hours per week
Mercy Hospital & Health Services
Auckland New Zealand

We currently seek an experienced Palliative Medicine Specialist. The purpose of this position is to contribute to the delivery of an exceptional standard of holistic medical care across the Hospice functions and to play a key role within the multidisciplinary team, as well as representing Mercy, its mission and its values both internally and externally.

We are seeking someone who has:

* Considerable experience in the field of Palliative Care

* An appropriate specialist qualification

* Exceptional clinical and communications skills

* A track record as a team player

* A commitment to the advancement of the profile of the hospice through networking and appropriate training and research

* A commitment to the Mission and Values of Mercy.

If you would like to know more about this position you may contact Jan Nichols, Hospice Manager on: (NZ) 0-9-623-5700 ext 8645. Alternatively you may contact the Human Resources Department for an information pack and application form on: (NZ) 0-9-623-5700 ext 8462 or email Cheryl Wight at: cherylw@mercy.co.nz

Closing date for applications is Friday 16 November 2001.

For more information about St Joseph's Mercy Hospice visit our website www.mercy.co.nz