

### Editor's note

Thanks to the contributors to this newsletter. We have articles on the developing relationship between Renal and Palliative Medicine, which was also discussed at a number of ANZSPM fora in Brisbane and Sydney in 2010. Dr Frank Brennan has written another fascinating book review and Dr Kees Lodder has offered an intriguing reflection on care of patients with delirium. Dr Bruce Foggo has also shared some time-saving initiatives developed at Mercy Hospice, Auckland. In the Letters from Abroad, we feature Project Hamrahi, a collaborative initiative of APLI and Pallium India.

Sincere thanks to Karen Cooper for her great assistance with the newsletter production over the past years. I am looking forward to seeing you all at the September ANZSPM Ars Morendi conference in Adelaide. This year's conference promises to be a wonderful opportunity to both refresh the spirit of our practice and to stimulate scientific enquiry.

**Odette Spruyt**  
Editor

### President's Report



It is with great sadness that we announce that Karen Cooper, our Executive Director, is leaving her job and moving onto to bigger and brighter things at the Cancer Institute, NSW. Karen has done wonderful things for ANZSPM over the last 2 1/2 years. She has really helped to drive our organisation to become much more efficient, productive and visible to government

and the wider medical community. Karen leaves us with the Society in a strong position and we hope our next Executive Officer can continue to improve and strengthen our Society.

By now, you will be aware of an improvement to our website and also the ability to renew online. Whilst the timing of this was a little later than we hoped, it will now be much easier to renew membership each year online, with a few clicks of the mouse. As well, the ability to do it via post or fax is still available.

The national forums were once again very well attended.

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We thank our sponsor MundiPharma for their valuable ongoing support. I would also like to thank our speakers – Prof. Janet Hardy, Dr Mark Boughey, Dr Sandy Macleod and Prof. Brian Kelly. The other people I would like to thank are the members who were available to convene each night in the various cities – Odette Spruyt, Frank Brennan, Carol Douglas, Lawrie Palmer, Mary McNulty, Maureen Mitchell, Paul Dunne, Joy Percy, Kate Grundy, Cathy Miller. All these people have given generously to the work of our Society.

On the advocacy front ANZSPM has continued to be very active. Our application for new MBS item numbers is still being processed, through the new MBS quality framework system. As well we are participating in a College of Physician's led attempt to provide the government with a subacute care sector consensus on what should be provided with the large amount of money given to the states under ongoing COAG funding.

We have met recently with PCOC and NSAP to continue our involvement in, and support of the quality improvement agenda. I wish to thank Odette Spruyt for her attendance on our behalf, at the National Pain Summit held in March.

The ANZSPM Conference in Adelaide (15th-17th September) is fast approaching and I encourage you (if not already attending) to think about coming. Our convenor, Greg Crawford, has developed a wonderful

educational and social program.

As part of our contribution to Continuing Professional Development we are planning to hold a Palliative Medicine update over 2 days in 2011. This will look at state of the art updates in Palliative Medicine, as well as other areas of medicine and surgery, as they relate to Palliative Medicine. This is in response to feedback from members as to the need for such an update. It will be held in Melbourne on Fri 29 – Sat 30 July, 2011. Please keep these dates in mind.

Thank you once again, Karen, and we wish you all the best for the future.

**Phillip Good President**

## *New Zealand Branch Report*



This will be the last newsletter I will be writing as NZ Branch Chair. I will be stepping down in September and handing over the reigns to Cathy Miller who has been on the ANZSPM Executive for the last 4 years in the roles of secretary and more recently treasurer of the executive. She is also an elected member of the ANZSPM council. I am delighted that she has

agreed to take on this role for the next year. We also have a new enthusiastic executive with a larger number of members than usual. This reflects our increasing responsibilities to our NZ members and NZ Palliative care initiatives. There are various projects underway at present and these will be reported in subsequent newsletters.

The executive members are as follows and represent many regions of NZ:

Joy Percy	[Palmerston Nth] - President
Cathy Miller	[Auckland] - Treasurer
Sara Rishworth	[Auckland] - Secretary
Sinead Donnelly	[Wellington] - Communications officer
Amanda Landers	[Christchurch] - Member
Peter Kirk	[Hamilton] - Member
Christian Robold	[Invercargill] - Member
Carol McAllum	[Hawkes Bay] - PCC Co-optee
Ian Smiley	[New Plymouth] - GP Co-optee
Oleg Kiriaev	[Auckland] - Trainee Co-optee

The Annual New Zealand branch conference at the beginning of May in Wellington was very well attended and received good feedback. The three ANZSPM forums in Christchurch, Palmerston North and Auckland at which Professor Janet Hardy was guest speaker were also successful. If these are repeated next year then we will consider holding them in different centres in order to increase the opportunity for members to attend.

The "Memorandum of Understanding" between the NZ branch and ANZSPM continues to progress with future discussion at the NZ Conference Business meeting on May 2nd. We hope this will be finalised at the September AGM.

On a national level the draft NZ service specifications are now out for consultation. Hopefully these will be collated and finalised by the end of the year. There is also national discussion about the development of Advance Care Planning, supported by two documents from a collaboration between the Ministry of Health and Hospice NZ called "Advance Care Planning for Adults: An Overview and Planning for Your Future Care".

I would like to thank the present executive and previous executive members for their support and work during the 4 years that I have been in the chair's role and 2 years prior to that as secretary. I would also like to thank Karen and the ANZSPM council for all their support of the NZ branch over my time on the council.

Last but not least, as you will be aware from this newsletter, Karen our EO is resigning this month. This was a new role created to increase the Society's presence and activity as a professional body. It was a big ask for anyone to develop this role but Karen has achieved an enormous amount in this time. From a NZ perspective, the development of information sharing via e-update, newsletters and the website stand out as major achievements and more recently the electronic subscription option. Karen's willingness to attend our NZ meetings and listen and learn of the NZ perspective has been most beneficial to us as a branch and I thank her for this and all the other things she has done to assist us.

**Joy Percy ( NZ Branch Chairperson )**

## *ANZSPM NZ Branch Executive*

ANZSPM (NZ Branch) is pleased to introduce 3 new members to its Executive: Christian Robold, Amanda Landers and Peter Kirk.



**Christian Robold;** New Executive Member, New Zealand Branch

I am 50 years old. I have been the Medical Director of Hospice Southland since March 2009.

Before this, I worked as a Palliative Medicine Specialist in Hannover, Germany from 2000 until February 2009. I attended patients in 3 hospices in Hannover. I participated in the set up of a Palliative Care network for the city and region of Hannover and in the development of its political framework. I was member of a working party that created a concept for a new Palliative Care Department at Siloah Hospital, Hannover, Clinic Centre Hannover Region (consortium of 13 community hospitals) and from August 2005 until February 2009, I was consultant of that department.



**Amanda Landers;** New Executive Member, New Zealand Branch, is a palliative care physician working in the Canterbury community for Nurse Maude Hospice. This is an inaugural position which will evolve with time. She has just finished working as a

consultant in the Northern Territory of Australia, covering the Top End of the continent and travelling remotely to work with Aboriginal Australians. Her current areas of interest are patients with non-malignant palliative care needs, especially those with renal and lung disease. Education is also a major focus.

Amanda has a husband who is kept extremely busy looking after their 5 children. All are pleased to be back in Christchurch embarking on new beginnings.



**Peter Kirk;** New Executive Member, New Zealand Branch

From 1984-2001 Peter worked in Family Medicine University of Manitoba at St Boniface General Hospital, Winnipeg

where he was Professor and Head from 1991-2001.

In 2002 he was Director of Research for Vancouver Island Health Authority and Medical Director for Palliative/EOL care.

His research interests are in communication in palliative care.

He was principal investigator for a NET CIHR 5year award in Palliative Care.

He is a Clinical Professor at the University of British Columbia and was the Director of the Division of Palliative Care.

He now works as a Palliative Care Specialist at Waikato Hospital, Hamilton, New Zealand.

## Delirium

### How can we alleviate the distress of people with delirium and their families?

#### Introduction

Distressing delusions experienced by terminally ill patients cause much anguish for the patient, family members and the healthcare providers. Family members have a great need to communicate with their delirious relative nearing the end of their life and they need help to find a way to achieve this. Whenever the patient becomes aggressive family members experience fear and can feel guilty, inadequate and powerless. There is often an intense distress due to the premature loss of contact before death. These experiences contribute to a traumatic grieving process.

#### Explaining delirium

Explaining the causes of delirium and the possible symptoms when delirium is anticipated to both the patient and their relatives and explaining that the patient isn't going mad usually relieves anxiety. Delirium is not just a physico-chemical disorder. Personal history, beliefs, fears, values and goals influences delirium. Discussing the principles around associative misinterpretations, delusions and hallucinations, can help to integrate patient's delirious experience with their personal history and philosophy when it arises. Including family members in the delirium treatment plan is often neglected. Exploring how to relate to delusions before symptoms occur enables both the family and the patient to have a sense of preparedness and control. These approaches help to build a therapeutic relationship with the patient and

their family. Once delirium is explained, family members can also be involved in the detection of delirium. Educated family members are often more attentive to and spend more time with the patient in order to provide reassurance. They also feel more confident in adopting the right attitude towards the delirious patient.

#### *Metaphors in delirium*

Content of delirium can be a metaphor. Metaphors can relate to the transition between life and death or represent life issues that have been unresolved and need reconciliation. Often there is communication with deceased relatives or the appearance of guides. Examples of these metaphors include talking about travel or preparation to travel or a searching for something or someone. The aim is to help the patient and their family to decipher and understand these metaphors which occur as a result of sensory misperception, hallucination or delusion.

Helping to make sense of these distressing experiences can help people to die peacefully and can result in a sense of completion for everyone involved.

#### *Transition between life and death*

Callanan and Kelley, in their wonderful book *Final Gifts*, give many examples of the change of consciousness and perception that can manifest during the terminal phase of the patient's life. They formulated the concept of 'nearing death awareness' to describe these transitional experiences between life and death.

#### *Working with delirium*

What does it take to open up to the experience of the delirious patient? How can we approach people who experience delirium with understanding and compassion? Compassion means to be with someone's suffering. It reflects our ability to enter their world with empathy and sympathy. This requires a paradigm shift in order to focus on what the delirious patient is conveying and not assume that the experience is solely due to their underlying medical condition. We need to open up to the content rather than to ignore it. We need to be able to enter the dream-like world using our intuition to help to understand and let unfold the often absurd, chaotic and apparent meaningless experiences of the delirious patient. With a process oriented approach we can enter the river of delirium and help to unravel this new world from the inside by understanding it from a more intuitive compassionate way of being rather than a cognitive analytical way. It requires a willingness to enter the world of the unknown. We need to use communication

that connects us with the delirious patient in order to help the patient feel related rather than alienated. This work does not need to take long but requires trusting ones inner responses.

*Some abbreviated case studies to illustrate how to apply this process:*

1. A patient on the 10th floor of the hospital was distressed because he felt we were being attacked from the outside of the building. I spotted a telescope in the family room where we were speaking which he interpreted as a machine gun. I asked him whether I could take him to a safe place at the other side of the building. He agreed and was a lot more settled. After his infection was treated he recollected his experience and thanked me for taking his distress seriously.

2. A very agitated man was pacing up and down his room and required constant observation. The observer was sitting at the entrance of his room and did not interact with the patient. I could not understand a word of what the patient said and experienced his extreme distress. I expressed to him that it must be so awful to feel so distressed and that nobody understands him. He sat down and stopped talking. He seemed more relaxed. I asked him what he loved the most in his life. His first clear word was "fishing".

3. The daughter of a woman who is dying talks about her loss of her husband in a car crash and her grief for the two people she loved the most. Her mother starts to see her daughter's husband during her delirium. This experience was very reassuring for her daughter.

4. A Scottish man with renal failure started to experience mild delirium. In the presence of his family we discussed delirium. I asked him whether he had an image for what he was going through. He replied that he could see the grass of the Scottish Highlands moving in the wind. I asked what it meant for him. He replied that he would like his ashes to be scattered over the Highlands. Close to death he conveyed to me that he could see the grass moving in the wind. He died peacefully in the presence of his family. People are often frightened of the people they see during their delirium. To help them to see them as allies relieves much distress.

Working with delirious terminally ill patients and including family members in the treatment plan is immensely

satisfying work. It shows that we can communicate with a patient who might be experiencing a very different reality from our own.

**Kees Lodder**  
**Palliative Care Specialist in Auckland, New Zealand.**

## *Rules & Regulations & The Filling in of Forms*

*Rules & regulations and the tedium of writing the same thing over again are part and parcel of everyday hospice life. But wait..... Some things can be streamlined and some practices made safer. Dr Bruce Foggo at Mercy Hospice Auckland describes two initiatives, one that has legitimised a previous "grey area" of practice and another which has reduced the tedium of completing cremation forms.*

### **Developing a Standing Order .... Why bother?**

Hospices and palliative care services by their nature and philosophy tend to be generous and facilitating in their response to patient needs as they arise and particularly when changing circumstances dictate that things "happen quickly". In meeting these needs rules may occasionally be bent or overlooked. This is of no consequence where the action or outcome poses no danger to patient or staff member. But where the need is for supply of medication outside of a named prescription or drug chart, the professional risk to the supplier of the medication and the health risk to the patient are too great to allow this to happen.

It was this circumstance that led us to investigate the utility of the Medicines (Standing Order) Regulations 2002 to allow for the safe and legal supply of medication for patients on short-tem leave from the hospice in-patient unit, without the need for a new prescription, and in the absence of a doctor on-site to provide the medication.

Previous practice when the need arose (invariably at short notice, and when the "on-call" Dr had just gone home) was for the Inpatient Unit coordinator to discuss the need with the on-call Dr and obtain "authority" to supply sufficient regular and PRN medication to meet the patient's need for the period of leave. This process however contravened the Medicines Act and was technically seen as dispensing without proper authority and process.

The standing order for the supply of medication for patients on leave from the hospice in-patient unit provides a safe and legal mechanism for supply of medication already charted on the in-patient drug chart for periods of leave of up to 24 hours. It was developed in conjunction with our pharmacist and scrutinised and amended on legal advice.

Standing orders were originally intended for use in emergency situations within a hospital but are now used in a variety of settings and there is the potential to utilise standing orders for other hospice services and to legitimise some established hospice practices (E.g. provision of syringe driver prescriptions for community patients from the hospice in-patient unit)

The Ministry of Health provides Guidelines for the Development and Operation of Standing Orders (available at <http://www.moh.govt.nz/moh.nsf/pagesmh/3398?Open>) which interpret the detail of the regulations and has a checklist of requirements to be met for a standing order to be valid.

### **An on-line Cremation Form**

Cremation forms are cumbersome & tedious to complete requiring as they do a lot of repetitive information to be entered. At Mercy Hospice, Auckland we have partly solved the tedium by developing an online template form with most of the repetitive information (Hospice address, where did the patient die? etc) being pre-entered. There are highlighted fields for non-standard answers to be typed and a tab function that moves to the next required field. The typed forms have been accepted by funeral directors and local medical referees.

We would be happy to talk further with anyone contemplating the development of a standing order or would like a copy of our on-line cremation form template. This can be supplied as a formatted document minus our logo & identifiers or we can format a document for you.

If any of this is of interest to ANZSPM members or hospices, contact Bruce Foggo at [bruce.foggo@mercyhospice.org.nz](mailto:bruce.foggo@mercyhospice.org.nz).

**Bruce Foggo**  
**Clinical Director**  
**Mercy Hospice, Auckland**

**CONSULTANT PALLIATIVE CARE – ADELAIDE**

**Name of Facility:** Royal Adelaide Hospital Cancer Centre

**Basis:** Permanent Full Time

**Salary:** \$163,897 - \$215,959, plus salary sacrifice, superannuation, private practice

The Royal Adelaide Hospital in South Australia is looking for a Consultant in Palliative Medicine.

Royal Adelaide Hospital was founded in 1840 and is incorporated under the South Australian Health Commission Act, 1976. Royal Adelaide Hospital consists of three campuses - North Terrace, Hampstead Rehabilitation Centre and St Margaret's, and associated outreach services. Royal Adelaide Hospital provides a specific range of tertiary referral services to the people of South Australia and the nearby states and territories, and a broad range of clinical services to people who rely on Royal Adelaide Hospital as their regional or local hospital.

It is also involved in various areas of medical and health research, often in conjunction with the Institute of Medical and Veterinary Science (IMVS) and the University of Adelaide, for which it is a major teaching hospital and is closely affiliated with the Hanson Institute. In addition, a wide range of general as well as specialised clinical rotations are available.

As Royal Adelaide Hospital is an accredited teaching hospital for all health professionals it offers basic training positions in internal medicine, surgery, and general practice, as well as advanced training in many medical specialties.

The person we are seeking will be eligible for Fellowship of the Australasian Chapter of Palliative Medicine (or equivalent) and will have demonstrated skills working in a multidisciplinary team.

If you would like further information regarding this position you can contact:

Dr Michael Briffa  
Director Palliative Care  
[michael.briffa@health.sa.gov.au](mailto:michael.briffa@health.sa.gov.au)  
Telephone +61 8 8222 2019

Job and person specifications are available from [christine.jarrett@health.sa.gov.au](mailto:christine.jarrett@health.sa.gov.au)



## Palliative Care Physician/Specialist

Auckland City Hospital  
New Zealand

The Hospital Palliative Care Team has vacancies for doctors in palliative medicine as either one year fellows or as specialists.

These full time posts are clinical positions working throughout the hospital in all adult medical and surgical services, providing consultative patient-focussed specialist palliative care in conjunction with the multi-disciplinary team.

Auckland City Hospital is a large tertiary institution and is a teaching hospital of the University of Auckland with active undergraduate and graduate programs. This is an opportunity to work in an expanding hospital palliative care team that includes Nurse Specialists, a Nurse Practitioner, Advanced Trainees, rotating registrars and LCP facilitators. The team is actively involved in teaching and research activities as well as service development projects regionally and nationally.

You will require FACHPM qualification or equivalent and must be eligible for vocational registration with the New Zealand Medical Council. All enquires are welcome.

In addition to a great job, the natural beauty of Auckland and New Zealand offers you a wide range of lifestyle opportunities including sailing on the Auckland Harbour; easy access to many beaches; the New Zealand native bush and snow covered mountains.

ADHB is an accredited employer with NZ Immigration service so we can help with your immigration requirements and can also provide relocation assistance.

For enquiries or more information about the position, please contact Dr Anne O'Callaghan, Clinical Director on [anneo@adhb.govt.nz](mailto:anneo@adhb.govt.nz)

To apply, please visit our website <http://careers.adhb.govt.nz> quoting reference number **018839** and apply on line attaching a detailed CV. For help with your online application or to request a position description, please contact Michelle Apetera, Recruitment Consultant on [mapetera@adhb.govt.nz](mailto:mapetera@adhb.govt.nz).



## *Book Review*

### **Right to die**

Hazel McCaffie, Luath Press, 2008, pp 316.

Motor Neurone Disease (Amyotrophic Lateral Sclerosis or Lou Gehrig's Disease) is diabolical. It is an incurable, progressive neurological disease. It comes down from the mountain of illness and pillages without mercy. It affects such vital parts of ourselves as our power, our speech, our swallowing, our breathing and usually, as it unfolds, it does so simultaneously. It challenges all notions of dignity and hope. It places enormous burdens on family and carers. What are the human responses to such a disease? Hazel McCaffie's novel *Right to die* places the reader directly in the sight and sound of this illness as it affects a young man and his wife.

McCaffie is a nurse and a novelist. She brings a clear and reliable professional sense to the course of the disease. As the novel commences, the main character, Adam, a brilliant young journalist, is dead. He has left behind an electronic journal. It charts his course from the subtle onset of symptoms, diagnosis, management and the emotional responses to his deterioration and all the multiple losses he endures. Rather than a traditional narrative McCaffie has chosen a clever structure. At his death Adam leaves his wife, Naomi, a note informing her of the existence of the journal. In her grief, she turns to it, not without reservation, and reads it. The reading is a journey of often painful discoveries: repeatedly she realizes she had no idea he felt that way. Key events, crucial conversations she now returns to, appalled and occasionally stunned by Adam's internal voice as he faced the multiple challenges the illness gave his body, mind and spirit. This repeated shift from the past in Adam to the present in Naomi gives the novel considerable momentum as the reader is drawn to hear their thoughts.

Adam describes his deterioration well. The worsening peripheral power, the dysarthria, the greater reliance on physical aids. Repeatedly he looks askance at all help as clear symbols. For Adam the symbols are not so much signs of disease progression as further threats to his independence. He is a thoroughly independent man. That presents problems for his wife and mother as they struggle, often unsuccessfully, to be present to a young man but not assuming, caring but not crowding. That robust independence is most evident in one of the central themes of the book – Adam contemplates suicide or euthanasia rather than "prolonging the horror". He visits and revisits that thought throughout the book. Adam articulates his reasons: not wanting to be a burden to his

wife and the fear of a life stripped of all dignity. Counterbalancing that is his knowledge that such an action would cause enormous distress to his wife and his sensitivity to his mother who had already lost her husband, Adam's father, to suicide. That internal debate is echoed and broadened when Adam raises this topic with his General Practitioner. Readers working in Palliative Care will be familiar with the arguments. What this novel illustrates is the powerful emotions of intimate loved ones when they realize that the ill person is contemplating such an action.

Therein lies one of the challenges for the reader in the married couple. They are loving but only occasionally confiding. They keep critical things from each other. Often in trying to protect each other they deny each other a chance for depth of understanding and intimacy.

The health professional characters in the novel are well drawn. The neurologist, the General Practitioner, the Physiotherapist – are compassionate in treating a young, brilliant man whose life is cascading away. Lydia, the Physiotherapist, threatens to steal every scene in which she appears – her wit, wisdom and capacity to sense the seismic shifts in Adam's moods and preoccupations are models of professional acumen. Hers is a wonderful and sympathetic character.

Readers who work in Palliative Care will read this novel at a further level – what, if any, is the involvement of our discipline in the illness? There is no formal Palliative Care involvement. This absence, however, is ably filled by the support, counselling and organization of the General Practitioner. At crucial points along the trajectory of Adam's illness he addresses the physical and psychospiritual issues. Indeed, the novel reinforces the critical importance, in the management of MND of a clear, organized and systematic approach to the patient and their family and carers. Without that approach all is chaos, all treatment, where it occurs, is reactive and never planned and everyone involved staggers from one crisis to another. This disease is horrendous enough without it being compounded by a lack of foresight, planning and organization. As Naomi describes it, MND is "a myriad of little deaths". Each loss should be anticipated and managed.

McCaffie has written a fine novel that travels with courage into difficult areas – incurable disease, euthanasia, suicide, faith, and loss of personhood, hope and ultimately the nature of love in the face of serious illness.

**Frank Brennan, FRACP, FRChPM**  
**Palliative Medicine Physician**

*Letters from Abroad***Project Hamrahi ("Fellow Travellers")**

Project Hamrahi is a collaboration between Australasian Palliative Link International (APLI) and Pallium India. The objectives of Project Hamrahi are to assist in the development of Palliative Care in India, support and mentor palliative care professionals in India who may be isolated and/or inexperienced and who request such support and to establish long term collegial relationships between palliative care professionals in both countries.

In January 2010, a "Train the Trainer" workshop took place at Peter MacCallum Cancer Centre. The eight participants shared previous experience teaching in resource-poor areas, travel and survival tips, and insights into teaching across cultural and clinical practice differences and also an exploration of motivations for participating in such a mentoring program. Several participants then attended the Indian Association of Palliative Care conference February 2010, in Trichy, Tamil Nadu. Some were also able to visit the Pallium India centre in Trivandrum. This exposure to the Indian palliative care community and clinical practice was a very valuable introduction to palliative care realities in India and would be recommended for all future volunteer mentors for this Project.



*Project Hamrahi group, IAPC conference, Trichy Feb 2010; Sok-Hui Goh, Trish McKinnon, Meera Agar, Odette Spruyt, Professor Rajagopal, Anil Tandon, Judith McEniery*

The first Project Hamrahi visit occurred in July 2010, to the Indira Gandhi Institute of Medical Sciences, Patna, Bihar in northeast India. This is a superspecialty hospital which includes a regional cancer centre. Dr Vinod Verma, an anaesthetist, heads the new palliative care service at IGIMS. He attended the Pallium India training in late 2009. He has set up a daily OPD, which runs next to the oncology OPD. He is also responsible for maintaining opioid supplies for the Institute, which are limited to oral 10mg and 20mg immediate release morphine, 30mg slow release morphine, injectable 10mg/ml morphine and fentanyl 100ug/ml. Morphine is dispensed by a senior nurse in neuro OPD, Sr Alaama Joseph, who also maintains the inventory of opioids and the patient details. There are no medications kept on the wards, with patients buying all medications from a private pharmacy on the hospital grounds. A six-bed area is ear-marked for palliative care, on the same ward as the oncology public patients. The new palliative care service is supported by the Director of the Institute who is also head of Anaesthetics.

The program for my one week visit was to do a ward round or OPD clinic each day with Dr Verma or one of the oncology senior residents or consultants, meet with the Director of the Institute and senior staff in oncology and anaesthetics/palliative care to discuss the further development of palliative care, interactive teaching and discussion with senior residents and other specialty staff, lectures to Clinical Oncology Society, nursing students and a grand round, and much time with Dr Verma developing an understanding of the particular challenges he faces in developing palliative care. I also spent time learning about the complexities of opioid prescribing and availability at the Institute.

Some satisfying and memorable experiences included guiding a gynaecological oncologist as she wrote her first script for oral morphine, demonstrating the effectiveness of haloperidol for nausea management, demonstrating the marked efficacy of oral morphine to the oncologist who referred the patient, a case-based discussion with the ICU consultant about the importance of patient autonomy in the Australian practice of medicine and his readiness to learn from this clinical case. I was struck by the late presentation of many patients, the focus of the treating teams on expensive diagnostic and disease modifying therapies and the absence of discussion of end of life care planning and palliative, symptom focused approach to care for incurable disease.



*Drs Vinod, Sangrita & Pritanjali prescribing morphine*

There will be many challenges ahead in establishing palliative care at IGIMS. APLI with Pallium India, will provide me with funding for 2 further visits over the next 4 years. It is salutary to note that many Indian doctors undertaking the task of beginning palliative care in major hospitals do so with only 6 weeks of formal training in one of three centres, all based in the south of India. And all with minimum resources and staffing levels. It is very rewarding and exciting to be part of this development, the impact of which can be so far reaching. In terms of my own medical practice, involvement in Project Hamrahi also emphasises the importance of ensuring that palliative care is strongly integrated into the model of cancer care in Australia and demonstrating this to our colleagues in resource-poor areas. Providing these doctors with the knowledge and skills required, including communication skills, clinical decision-making skills and pain and symptom management skills and modelling compassionate care is an important role that academic institutions have in our increasingly interconnected global community of practice. If you are interested in Project Hamrahi, please contact Odette Spruyt at [odette.spruyt@petermac.org](mailto:odette.spruyt@petermac.org).

**Dr Odette Spruyt,**  
**Chair, Australasian Palliative Link International**

### *Renal-Palliative Care – Recent developments in Australia*

The importance of the interface of Palliative Medicine and non-malignant diseases has been widely recognised for years. Moving from that recognition to sustained clinical work, true collaboration, mutual respect and research has taken longer. One of the diseases that has witnessed a growing collaboration is End Stage Renal Disease (ESRD). The growth and maturation of the disciplines of Nephrology and Palliative Medicine has seen some interesting parallels. Over the past decade there has been an emerging, although still limited, confluence of the disciplines in the USA, the United Kingdom and Canada. That confluence has emerged from a mutual recognition of need – the growing numbers of people with ESRD on Renal Replacement therapy (haemodialysis, peritoneal dialysis and transplantation), the significant morbidity and mortality associated with ESRD – with or without dialysis, the importance of a conservative pathway for patients where dialysis is not appropriate, the burden of symptoms and the needs of dying patients and their families.

The last few years – and more particularly the last year- has seen several significant developments in this interface in Australia. They include:

1. Collaboration between the Palliative Care and Nephrology Departments in Darwin, Ballarat, Melbourne and Sydney.
2. The establishment in March 2009 of a Renal-Palliative Care Clinic at St George Hospital, Sydney. That clinic comprises a multi-disciplinary team of a Palliative Care Physician, a Renal Medicine Trainee, a Renal Clinical Nurse Consultant and a Renal Social Worker.
3. The formation by the Victorian Department of Health of a Committee on Renal-Conservative Care, comprising representatives of both disciplines.
4. In 2010 the appointment by the Victorian Department of Health of a Renal Conservative Care Project Officer.
5. Renal-Palliative Care Symposia conducted at Orange NSW in December 2009, Royal Melbourne Hospital in March 2010 and one planned at St George Hospital in August 2010.
6. The ANZSPM Fora of 2010. In Brisbane and Sydney the lectures were on Renal-Palliative Care. They were presented by Associate Professor Mark Boughey, Palliative Medicine Consultant, St Vincent's Hospital, Melbourne.

7. The recent announcement by the NSW Department of Health of funding over three years of two new clinical positions – unique in Australasia – of a Renal- Palliative Care Physician and a Renal- Palliative Care Nurse to be based at St George Hospital in Sydney.

Clearly these developments are occurring rapidly. The relationship between the two disciplines shall continue to grow. The challenge will be the channelling of that cooperation into mutual support towards patient benefit.

The Renal-Palliative Care Symposium in Sydney will be held on August 13 2010. It shall be co-hosted by the Departments of Renal Medicine and Palliative Medicine at St George Hospital. For those interested in attending the Registrant is Liz Josland, Renal CNC. She can be contacted on : Elizabeth.Josland@sesiahs.health.nsw.gov.au or by telephoning 02-91131111.

**Frank Brennan FRACP FRChPM**  
**Palliative Medicine Physician**

### Conference update

<p><b>Healthcare Reforms in Comparative Health Systems</b>  <i>Date:</i> 4-6 September 2010  <i>Venue:</i> Hong Kong  <a href="http://www.medcom.com.hk/racma.hkccm">www.medcom.com.hk/racma.hkccm</a></p>	<p><b>3<sup>rd</sup> Annual International Hospice and Palliative Care in Developing Countries Conference</b>  <i>Date:</i> 23-25 September 2010  <i>Venue:</i> Fresno, California, USA  <i>Email:</i> <a href="mailto:nancy@hindshospice.org">nancy@hindshospice.org</a> or <a href="mailto:jill@hindshospice.org">jill@hindshospice.org</a></p>
<p><b>Reform in Primary Health Care</b>  <i>Date:</i> 28-29 September 2010  <i>Venue:</i> Citigate Central, Sydney, Australia  <a href="http://www.primaryhealthreform.com">www.primaryhealthreform.com</a></p>	<p><b>3<sup>rd</sup> African Palliative Care Association Conference International Primary Palliative Care Research Group</b>  <i>Date:</i> 15-17 September 2010  <i>Venue:</i> Windhoek, Namibia  <a href="http://www.apca.org.ug/index.php">www.apca.org.ug/index.php</a></p>
<p><b>12<sup>th</sup> National Solace Grief Conference</b>  <i>Date:</i> 8-9 October 2010  <i>Venue:</i> Sydney, Australia  <i>Contact:</i> Ken 02 9529 4805, Margaret 02 4655 1575, email <a href="mailto:solacensw@gmail.com">solacensw@gmail.com</a></p>	<p><b>In the Spotlight: Patient Centred Care</b>  <i>Date:</i> 2-3 September 2010  <i>Venue:</i> Brisbane, Australia  <a href="http://www.changechampions.com.au">www.changechampions.com.au</a></p>
<p><b>18<sup>th</sup> International Congress on Palliative Care</b>  <i>Date:</i> 5-8 October 2010  <i>Venue:</i> Montreal, Canada  <a href="http://www.palliativecare.ca/en/index.html">www.palliativecare.ca/en/index.html</a></p>	<p><b>The International Society for Quality in Health Care (SQua) 27<sup>th</sup> International Conference</b>  <i>Date:</i> 10-13 October 2010  <i>Venue:</i> Marriott Rive Gauche Hotel, Paris, France  <a href="http://www.isqua.org/current-conference.htm">www.isqua.org/current-conference.htm</a></p>
<p><b>37<sup>th</sup> COSA Annual Scientific Meeting</b>  <i>Date:</i> 9-11 November 2010  <i>Venue:</i> Melbourne Convention and Exhibition Centre, Melbourne, Australia  <a href="http://www.cosa.org.au">www.cosa.org.au</a></p>	<p><b>First International Forum on Palliative Care</b>  <i>Date:</i> 11-14 November 2010  <i>Venue:</i> Budapest, Hungary  <a href="http://www.imfpc.org">www.imfpc.org</a></p>



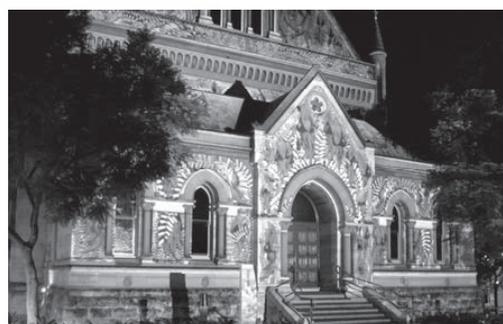
**AUSTRALIAN AND NEW ZEALAND SOCIETY OF PALLIATIVE  
MEDICINE CONFERENCE  
14 – 17 SEPTEMBER 2010  
ADELAIDE, SOUTH AUSTRALIA**

### Ars moriendi - Palliative Medicine in the 21st Century

#### VENUE

Festivals, food and wine. Arts and culture. Shopping and sports. This is Adelaide - the Australian city where there's always something on.

South Australia's capital has it all, with spacious boulevards and vibrant inner-city districts, sophisticated architecture and lush gardens. You can immerse yourself in the culture of Adelaide's North Terrace, with its museums and city cafes. Or you might want to indulge in retail therapy while shopping at Rundle Mall, sample the tastes on offer at the famed Adelaide Central Market, or sip award-winning wines at the National Wine Centre or close by in the Adelaide Hills or Barossa Valley. In Adelaide, there is a brilliant blend of things to see and do.



#### CONFERENCE PROGRAM

TUESDAY 14 <sup>TH</sup>		WEDNESDAY 15 <sup>TH</sup>		THURSDAY 16 <sup>TH</sup>		FRIDAY 17 <sup>TH</sup>	
Trainees Day	Knowledge into Practice Workshop			Current approaches for the management of opioid-induced constipation in the palliative care setting symposium Sponsored by Pfizer			
				ANZSPM AGM		AChPM Meeting	
		<b>OPENING SESSION</b> The artworks of death and dying Ian George AO  Poco Tutti Choir Performance  <b>PLENARY SESSION</b> Assessment of depression in palliative care - problems and solutions Mari Lloyd Williams		<b>PLENARY SESSION</b> Is it important for you to know that opioids work beyond the mu receptor? Andrew Somogyi  Palliative care for dementia - how can services be developed? Mari Lloyd Williams		<b>PLENARY SESSION</b> Finding and generating evidence in palliative care: CareSearch's role Jen Tieman  The cancer support group-connecting people Mark Robson  Living and dying at home: The role of GPs in community palliative care Mary McNulty	
		MORNING TEA		MORNING TEA		MORNING TEA	
		<b>PLENARY SESSION</b> Legalising euthanasia: Why now? Margaret Sommerville AM  Dying observed Sinéad Donnelly		Concurrent sessions	Ethical cases workshop	GP Stream	Concurrent Sessions
	Supervisors Workshop	LUNCH		LUNCH		LUNCH	
		Concurrent sessions	Care of the dying pathways workshop	Concurrent sessions	Psychodynamic Psychotherapy at the end of life workshop	<b>PLENARY SESSION</b> Famous literary deaths Sandy Macleod  Lessons from my Mother Dorothy Keefe  <b>FUTURE PLANS</b> Close of Conference	
		AFTERNOON TEA		AFTERNOON TEA			
		Concurrent sessions	Care of the dying pathways workshop (cont)	Concurrent sessions	Art Gallery tour		
		WELCOME RECEPTION		CONFERENCE DINNER			

◆ [Link to Conference website from www.anzspm.org.au](http://www.anzspm.org.au) ◆

#### CONTACT

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