

Editor's Note

In this edition we bid farewell and offer our thanks to Odette for her stalwart editorship over the last years and her services to ANZSPM. Through a moment of inattention, I find myself filling extraordinarily large shoes, fortunately with great guidance and collegiality.

In our final edition of the year, we reflect on the vibrant conference in Adelaide that brought to focus the many challenges the specialty holds for the future. The clarity of thought from M Somerville and earnestness of the Poco Tutti choir must surely be a reminder of our role as guardians of the philosophy of care of our specialty. Developments such as the PaMTraCC in New Zealand and the achievements of trainees (M Chapman) are encouraging examples of the endeavours of many to ensure the continuous growth and credibility of Palliative Medicine as a speciality.

Palliative Medicine demands that we continuously up skill in our medical knowledge whilst remaining well routed within our humanity. Book reviews by A Dabscheck and F Brennan as well as upcoming conferences and retreats highlight these contrasts whilst D Brumley's narratives of Hiroshima and research forums in Cape Town are reminders of the 'bigger picture' to which we belong – consciously or subconsciously!

A big thank you to Marita, who like me, is a newcomer to this task. We somehow managed to muddle through this together through work schedules, school runs and piano lessons! And finally, after years of mulled wine and mince pies in Europe, I have been forewarned re the Australian Xmas's of BBQ's, Beers and hopefully no bushfires. I wish you all the warm comfort of family and friends over the festive season, until we catch up again in the New Year.

Natasha Michael
Editor

President's Report

The ANZSPM conference in Adelaide had many highlights and received very positive feedback. Wonderful overseas and local speakers coupled by Greg Crawford's unique music extravaganza, made it a memorable event. Special thanks to Greg for a wonderful program and for providing many of the musical highlights himself with his impressive piano playing. Many of the musicians provided their services for free and I'd like to thank them for making the conference so warm and unique.

I am not sure I have experienced an ANZSPM conference quite like it - with the protests on Parliament House, formal and informal networking! We all look forward to the next conference, in Queenstown, New Zealand, September 2012. It will surely have its own unique flavour.

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Our AGM was well attended, with the election of our new President-Elect, and several new Council members. The current Council members are listed below.

Dr Phillip Good	President (Chair)	Qld, Australia
	Elected Councillor	
Dr Frank Brennan	President Elect	NSW, Australia
	Elected Councillor	
Dr Cathy Miller	NZ Chair/Secretary	New Zealand
	Appointed Councillor	
A/Prof Rohan Vora	Treasurer	Qld, Australia
	Elected Councillor	
Dr Michael Chapman	Trainee Representative	
	Elected Councillor	Vic, Australia
A/Prof Mark Boughey	Elected Councillor	Vic, Australia
Dr Ashwini Davray	Elected Councillor	WA, Australia
Dr Carol Douglas	Elected Councillor	Qld, Australia
Dr Lawrie Palmer	Elected Councillor	SA, Australia
Dr Michael Briffa	Appointed Councillor (ex officio)	SA, Australia
Dr Mary McNulty	Appointed Councillor	WA, Australia
Dr Joy Percy	Appointed Councillor	New Zealand

A major topic at our conference (and post AGM) was the push for legislation legalising euthanasia and physician assisted suicide in Australia. I, like many, have been surprised at the rapidity of the push in almost every state and territory, so soon after an historic federal election resulting in a minority government. ANZSPM recently updated its position statement on "The Practice of Euthanasia and Assisted Suicide". It is

available on our website or directly via <http://www.anzspm.org.au/c/anzspm?a=sendfile&ft=p&fid=1275955297&sid>

Following further discussion, the ANZSPM Council believes the best way forward is to:

- 1) Promote our position statement,
- 2) Ask that individuals make their own opinion known (or sign a collective letter), and
- 3) Consider that the ANZSPM role in this debate is to promote the discipline of Palliative Medicine.

We realise that it will disappoint some members that we are not directly opposing legislation, but we have to keep in mind that the purpose of our society is to promote the discipline of Palliative Medicine. We welcome any feedback from members on this topic.

ANZSPM has also recently endorsed the National Pain Strategy. Details are at: <http://www.anzspm.org.au/c/anzspm?a=da&did=1000948&pid=1288875649>.

I have also recently met the Australian Minister for Mental Health and Ageing, the Hon Mark Butler MP, and I have since written to him regarding ANZSPM's position on the benchmark number of specialists required in Palliative Medicine and how we are working to attract more doctors to the specialty.

ANZSPM will once again hold National Forums in Australian and New Zealand cities in early 2011. We look forward to continuing this annual event, which is gaining popularity and thank Mundipharma for its generous sponsorship.

With the year drawing to a close, I wish everyone well for Christmas and 2011.

Phillip Good, President

New Zealand Branch Report

This is my first update as Chairperson for the NZ Branch as I step into the role vacated by Joy Percy. On behalf of our membership, a big thank you to Joy for the hard work over the last four (yes 4!) years. It is not until one steps into another's shoes that one really comes to understand what the task involves, and how efficiently ones predecessor has been doing it. She has been an extremely hardworking, competent chair, and is a collaborative worker who has accomplished an enormous amount.

Joy remains as Conference Convenor for the next ANZSPM conference in Queenstown, a member of the NZ Branch Executive and on ANZSPM Council.

We are fortunate to have a strong, vibrant executive with seven elected and three co-opted members. Sinéad Donnelly is organising the 2011 NZ Branch Annual Education and Business Meeting in Wellington on the 9th and 10th of April 2011 with a bioethics workshop planned for the preceding

Friday. Prof Margaret Somerville will be speaking by video link from Canada. Feedbacks from recent meetings have been very positive and networking opportunities valued. The venue will be Brentwood Hotel, Wellington. Registration will be open to ANZSPM members only to make for a smaller, somewhat cosier meeting, with more opportunities to network within the membership.

Sinéad has also completed a submission on behalf of ANZSPM (NZ Branch) to the Skills Shortages Review Office, Department of Labour, Wellington, asking that the category of Specialist Physician in Palliative Medicine remain on the Long term Skill Shortage List. If our application is successful overseas doctors who secure a post in New Zealand may obtain a work permit under the LTSSL work to residence policy.

Other members include Sara Rishworth, Minutes Secretary, Amanda Landers, Christian Robold, and Peter Kirk. We also have three co-opted members, Ian Smiley, representing the interests of GPs practicing in Palliative Medicine, Carol McAllum, ANZSPM nominee to the Palliative Care Council and Oleg Kiriaev, representing the interests of trainees.

The NZ Branch Executive is pleased to welcome Marita Linkson, who recently replaced Karen Cooper as Executive Officer for ANZSPM. Marita attends our monthly teleconferences, supports us in many ways and took the opportunity in Adelaide to meet those members of our executive who were present.

A significant task of importance to the NZ Branch, is the MOU between the NZ Branch and ANZSPM Council. This document, mandated by our new constitution, sets out our mutual understandings, our relationship and how the NZ Branch is to be run. The final draft which goes forward to the ANZSPM Council in November is signed by both parties to be reviewed annually.

April 2011 is shaping up to be a busy month, as the forums are planned, with Dr Frank Brennan, scheduled to give the NZ presentations this year. Frank has an interest in Palliative Medicine in the setting of renal disease, and he will also be attending and presenting at our Wellington meeting.

It has been a great pleasure working closely with members of ANZSPM Council as an elected member, and I look forward to strengthening that relationship during my period as Chair of ANZSPM (NZ Branch).

We are here to serve our membership, and I invite all NZ members to forward any constructive or creative ideas about what ANZSPM can do to support your roles (directly to me, to Sinéad, Communications Officer or via your GP and trainee representatives Ian and Oleg).



Cathy Miller, President

Biographies

Dr Carol Douglas, MBCh.B, FRACGP, FACHPM, Grad. Dip Fam Med(Monash), Grad. Dip Pall Med (Wales)

Carol was raised a Kiwi. After four years in Houston working at Baylor in Cell Biology research she returned to NZ to study Medicine at Otago. Despite a move to Australia in the 80's she continues to barrack for the All Blacks. She is a keen gardener, photographer and skier.

From General Practice in Australia, Carol turned to Palliative Care after a formative experience in Kota Kinabalu Sabah. She and her family spent a number of years in Taiwan, China and Borneo with her husband's work. Carol endeavours to return annually to Sabah to help strengthen the Palliative Care service. Since 2005 she has been Director Palliative Care Service at the Royal Brisbane and Women's Hospital.

Clinical interests include Motor Neurone Disease, Renal Disease and Communication.

Carol is a member of the ANZSPM Clinical Indicators Committee, the PCA NSAP Steering Committee and Australasian Palliative Links International (APLI).



**Dr Lawrie Palmer
Director of Palliative Care, Modbury Hospital.**

Lawrie was born in England and raised on Kangaroo Island. He attended The University of Adelaide Medical School, graduating in 1977, trained in General Practice doing his intern and two resident years at The Queen Elizabeth Hospital.

He worked through World Vision in a Cambodian refugee camp in Thailand and as a GP in Christies Beach before heading to the USA for five years for study and work (with his wife Deidre). During this time Lawrie completed a Masters of Public Health at The University of North Carolina at Chapel Hill and the American Boards in Family Medicine.

On returning to Adelaide he worked in the Emergency Department of The Queen Elizabeth Hospital, subsequently being appointed Director for seven years. The family returned to the USA for a further four years and Lawrie taught at the University of Texas Southwestern Medical School at Dallas in Family Medicine.

Since returning to Adelaide in 1998 Lawrie has done further work as a GP and completed training in Palliative Medicine at TQEH. Lawrie has also worked at Southern



Adelaide Palliative Services based at the Repatriation General Hospital before moving to Modbury.

Ashwini Davray, MBBS, MD, FRACP

Ashwini graduated from Medical School in India and subsequently went on to do residency training in Internal Medicine from University of Columbia, New York, USA.

She worked in New Zealand at secondary and tertiary hospitals and it was while working as a Palliative Medicine registrar in Waikato hospital, Hamilton that she realised that this was what she wanted to do. She followed her husband to Perth, where he was completing his advanced training and commenced her training in Palliative Medicine there.

Post training, she now works as a consultant in a 20 bed Palliative Care unit in Perth's Western suburbs. Since joining this unit, it has grown from 10 to 20 beds and is now accredited for Advanced Training. She also works as an Associate Professor at the University of WA, teaching sixth year medical students.

Ashwini describes Palliative Medicine as her passion, and considers it a privilege to enable patients with incurable illnesses to live and die in comfort.

ANZSPM 2010

Ars Moriendi - Palliative Medicine in the 21st Century

The biennial scientific meeting of ANZSPM in Adelaide 14th - 17th September 2010

It might be seen as somewhat indulgent for me to comment on the recent ANZSPM conference in Adelaide. Having lived and breathed this conference for almost two years, it had become part of the background noise in my family and work life for such a time and came to a crescendo in June to September of this year. I had a great time organising this conference and even more fun when it was actually happening and I hope that those who attended did likewise. I was keen to continue the exploration of the scientific aspect of palliative medicine but also to look more seriously at some of the other expressions of death and dying in our society. Music is a large part of the personal support and resilience-building structure in my life and I was keen to weave music and art in all its forms into the conference.

I am grateful for the opportunity to pull together such a great bunch of people as the members of ANZSPM for the biennial scientific meeting. I have always found the ANZSPM conferences a place of learning and science but also just as importantly an opportunity for refreshment, renewal and fellowship. The model for ANZSPM has been very much to have a committee of one or two and this organising

committee really comprised me, Phillip Good, Mark Boughey, Karen Cooper and our professional conference organisers Will Organise. Having a continuing relationship with the same professional conference organiser has significant benefits as they understand our members and sponsors and the scope of our meetings generally.

The early tasks of securing international speakers, tying together speakers with a theme and logo, organising a conference venue and places for a Welcome Reception and Dinner and to establishing a personal invitation to likely sponsors were the most difficult and nerve-wracking part I think, although the actual work load and time commitment increased closer to the event.



I was pleased with the contrast and connection that Mari Lloyd-Williams and Margo Somerville brought to the conference. Psychological symptoms and the issues of dementia are still in need of much more investigation and understanding within palliative care. Ethical decision making and arguments about end of life care and decisions are

always pertinent. To discuss euthanasia, physician-assisted suicide and be aware of the issues is always of benefit.



Andrew Somogyi, an academic pharmacologist from Adelaide University took on the intent of the conference theme, as did many others, presenting an update on current thinking about analgesia as Dolor Moriendi, Pain and dying: Opioids in the 21st century. The New Zealand speaker, Sinéad Donnelly was outstanding with her stories and insights into real life clinical situations.

The Opening Ceremony set the tone for the conference. Poco Tutti, an inclusive choir felt the warmth and the mood of the conference and was as moved as we were by the power of their presentation. They truly epitomised the central tenet of palliative care – to celebrate, to value and to live life to the full. The intensely personal account of his own experience of death from Bishop Ian George AO, former Archbishop of

Adelaide, with exquisite and varied examples from visual art, was moving and nothing like what I had expected or asked of him. The Minister of Health for South Australia, John Hill, opened the conference and spoke well of the role of doctors in end of life care and the changes that are in progress in South Australia. Many thanks to all the members who offered papers, to all those who chaired sessions and to those who made the workshops a success. I called in many favours from friends and colleagues and many gave their time and talents generously, often without remuneration.

Thinking back I cannot believe that after deciding to use the South Australian emblem, the Sturt Desert Pea with its distinctive red and black colours that I found myself photographing the lighting show during the last Adelaide Festival of Arts one evening when I realised that the Conservatorium building was lit with a Sturt Desert Pea decoration. Look at your conference Program to see what a small point and snap camera on a tripod can achieve. That Poco Tutti and the choir in the foyer on the final day, Voices in the Wilderness, were both wearing red and black, I confess, was more good luck than good management

The Welcome Reception in the Mortlock Chamber, the original part of the State Library of SA was a stunning venue. When my mate Geoff with three other trumpeters blasted a Fanfare from the Clock balcony my spine tingled. Then Linda, a mezzo-soprano formerly with Opera Australia and a past volunteer with one of our South Australian Palliative Care Services and a good friend sang songs of death from the balcony. All with the hum of renewed friendships and the greeting of colleagues from far and wide, washed down with excellent South Australian wines and beer. Many thanks to Cooper's Beer for providing all our beer for the conference at the best price you will ever get – as a gift.



The Adelaide Town Hall was not available initially but luck, some persistence and a cancellation left us with the premium venue for the dinner. I do confess the opportunity to pipe diners in with the fabulous pipe organ was pure indulgence. And Fabio merits special mention for his harmonica jamming with the band. I think he has a standing invitation to join them whenever he is in Adelaide.

The dinner was an opportunity to eat good food, drink excellent wine and share good fellowship, or to just sit back relax and either listen or dance to the music.

I look back on ANZSPM Adelaide 2010 with satisfaction and renewed vigour to continue to care for those anticipating the end of their life. It is now time to start planning time off to be in Queenstown in the wonderful south island of New Zealand in 2012. See you there if not before.

Greg Crawford
Adelaide

Trainees Day

Tuesday the 14th September, the first day of the 2010 ANZSPM Conference in Adelaide, saw trainees assemble for a day of education on aspects of clinical palliative medicine. The varied program included areas as diverse as communication skills, paediatric palliative care and psychiatry.

All the way from Canada, Margaret Somerville's authoritative discussion of ethics in palliative care decision making was a particular highlight and a great appetiser for her outstanding presentation on euthanasia later in the conference. Later in the afternoon, Andrew Somogyi brought the field of pharmacogenomics to life with advice on practical considerations in this often challenging field.

Outside the formal presentations, the day was also a great chance to network with other trainees and catch up socially. Working in Darwin, my opportunities to meet other trainees to discuss issues relating to training are relatively limited, so this was particularly valuable to me.

The day was well received, ran smoothly and provided valuable information relevant to palliative care practice. All trainees attending are grateful to Michael Chapman for organising the program, as well as all the speakers for giving up their time.

Dr Cathy Corbett
General Medicine and Palliative Care Registrar
Royal Darwin Hospital

Palliative Training



The Royal Australasian
College of Physicians
New Zealand

Palliative Medicine Trainee Co-ordinating Committee (PaMTraCC) New Zealand

Government funding has been obtained for a special initiative to establish up to ten palliative medicine advanced

training positions throughout New Zealand. Other positions may also be available to registrars in certain locations where separate funding has been secured.

The NZ Committee that oversees the funding and allocation of training positions in Palliative Medicine, is the Palliative Medicine Trainee Co-ordinating Committee ("PaMTraCC"). PaMTraCC works closely with the Palliative Medicine Education Committee (PMEC), based at the Royal Australasian College of Physicians in Sydney (RACP). Committee members are Palliative Medicine Specialists from throughout NZ and local administrative help is provided by the NZ office of the RACP. The committee provides liaison for all trainees in PaMTraCC positions, and will assist with the co-ordination of training runs. Trainees may be required to undertake training in more than one palliative medicine setting and locality and such issues can be explored on an individual basis as they arise. PaMTraCC will also provide advice and support for all trainees and potential trainees.

PaMTraCC's aims are as follows:

- To provide national co-ordination and standardisation of palliative medicine training rotations.
- To assist in the co-ordination of training placements.
- To assist with the identification and co-ordination of short term attachments in palliative medicine for advanced trainees in other disciplines (e.g. Oncology, Geriatric Medicine, Internal Medicine etc), and for General Practitioners. These attachments are likely to be suitable for those trainees wishing to undertake the Diploma in Palliative Medicine, through the Australasian Chapter of Palliative Medicine.
- To assist the PMEC with the process of site accreditation in NZ.

There may be a potential role for the co-ordination of site accreditation in NZ under the auspices of PaMTraCC.

PaMTraCC Committee members:

Dr. Simon Allan (Chair)	Palmerston North Hospital
Dr. Jonathan Adler	Wellington Hospital
Dr. Brian Ensor	Mary Potter Hospice, Wellington
Dr. Anne O'Callaghan	Auckland Hospital
Dr. Alan Farnell	Waikato Hospital
Dr. Prue MacCallum (Trainee Representative)	Waikato Hospital
Dr. Kate Grundy	Christchurch Hospital

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Palliative Care Research

Primary Palliative Care Research Forum Report

On the 13th and 14th Sept 2010, the International Primary Palliative Care Research Group held a successful meeting of its diverse members at the University of Cape Town, under the auspices of the Division of Family Medicine. Its purpose was to continue to develop the network of primary palliative care researchers who believe that palliative care is a primary care discipline and that research in this area is especially needed to encourage evidence based practice.

There was broad representation, with delegates from Scotland, Australia, Canada, Belgium, Colombia, Uganda, England, Nigeria, Botswana, Namibia, Tanzania and South Africa. There was a cross section of professions involved in first contact patient care and having an interest in palliative care research including nurses, doctors, social workers and psychologists. "The research process - from conception to application" workshop included sessions on identifying research priorities, facilitated by Prof Scott Murray from Edinburgh; ensuring local relevance of research, by Prof Geoff Mitchell from Brisbane; accessing support in research endeavors, by Prof Fred Burge from Halifax, Nova Scotia; and collaboration in research by Dr Alan Barnard from Cape Town.

Nine delegates presented papers on recently completed research the quality and variety of the research demonstrated that there is much to be commended and many avenues for further research development.

Views from three African university programmes in palliative care were presented. Dr Lindsay Farrant of the Witwatersrand University, Dr Mhoira Leng from Makerere University, Uganda and Dr Liz Gwyther from the University of Cape Town. The forum concluded with a series of views of palliative care from each country. The diversity of practice and range of expertise was inspiring to hear, and served the purpose of mutual encouragement and support toward the objective of developing the evidence base and also patient outcomes at primary care level.

The next meeting will be held in Lisbon, Portugal on 17 and 18 May 2011, preceding the European Association of Palliative Care meeting – see <http://www.eapcnet.org/Lisbon2011>

For further information, visit <http://www.uq.edu.au/primarypallcare> or email Alan Barnard at abarnard@intermail.co.za

**Prof Geoff Mitchell,
Brisbane**

"Prognostic factors in the elderly, palliative, community-dwelling patient". M Chapman, B Le, A Gorelik

Introduction

The older palliative population is a distinct group and is more likely to have a non-cancer cause of death and to suffer from multiple co-morbidities which create challenges in prognostication in the community. Change in physical function is a component of many tools, is accessible and easy to apply in a community but is of most use in the last months of life³. This study assessed an older population of community patients for relationships between demographic factors, comorbidity, and level of physical function with time until death.

Methods

Consecutive admissions over 65 years to Melbourne Citymission Palliative Care (MCMPC) community service over 12 months were reviewed. Data including epidemiological data; functional data (AKPS and RUGADL); and a tabulation of important co-morbidities. Outcomes of relevance to the study were death, time to death from admission and the location of death.

Results:

132 patients met entry criteria, 82.6% had an active cancer diagnosis, 68.8% had known metastasis. IHD was the most common non-cancer illness (27.3%) and most had at least 2 co-morbid conditions. 82.6% had an AKPS of >50 and RUGADL scores demonstrated similar levels of function. 84.9% of patients died in the 12 months with a median time until death of 56 days. A low AKPS or a diagnosis of CCF correlated with a shorter time until death ($p < 0.05$).

Discussion:

This study adds weight to the evidence of the prognostic power of physical function. AKPS was predictive of dying and duration of survival which has not been previously demonstrated in an older community-dwelling, palliative population. Functional decline often characterises the final pathway towards death though the timing of this decline in a single individual is difficult to predict. Due to the variability of physical decline in the last months of life physical function is best used in combination with other factors to determine clinically meaningful prognostic assessments.

Co-morbidity did not add additional risk in this study despite the importance of co-morbidity as a risk factor for mortality and declining function.

An important question arising from this research is how best to extend prognostic accuracy for older patients in the community. Further study of frailty, may aid in clarifying this important question.

References on request

**Michael Chapman
Winner ANZSPM 2010 Trainee Award**

Letters From Abroad

Japanese Hospitality

The invitation came unexpectedly over dinner during the combined PCA/APHN meeting in Perth in 2009. Would I like to come to Japan in 2010, speak at the 15th meeting of the Japanese Society of Palliative Medicine and visit Hiroshima and Peace House Hospice? It came from Mr Hideo Harada, who works in palliative care development for the Sasakawa Foundation and Dr Yoshiyuki Kizawa, of the University of Tsukuba. It was accepted with alacrity.

Arriving at Narita and negotiating the bus system, I'm headed off to the highlands of Honshu to visit Kuni Watanabe in Tochigi. Watanabe-san is a palliative home care doctor – a rare breed in Japan. He has been successfully granted an emergency vehicle status and enjoys showing off his demountable flashing red light. Palliative care emergencies abound in Tochigi!

Watanabe-san is a traditionalist who enjoys the tea ceremony, is much attuned to the spiritual needs of his patients and a soba fanatic who loves his German Shepherd dogs! This is, after all, Japan, a place of contradictions. We did some home visits, attended a traditional Buddhist (Nichiren) funeral and stayed in a traditional Japanese hotel. Ryokan are worrisome for the uninitiated, especially in regard to footwear and hot baths. The former dangerous, the latter deliciously addictive.



Back to Tokyo and a lovely hotel in the Ginza. Then out for a riotous dinner with Vimala-san, an Associate Professor at Koyasan University, and Nakano Tozen-sensei, Professor of Soto Zen in Tokyo. Here as in my past experience, the religious make interesting and high-spirited dinner table conversation and enjoy a good night out.

The following day we take the shinkansen – fast train to Osaka and local trains and a cable car up to the gorgeous isolated hilltop university town of Koyasan which gave my travel companion Harada-san and me a reflective respite. We stayed for a few days in Muryoko-in, a traditional temple, and wandered this serene old town that was founded by and is home to the mausoleum of Kukai, a wandering Buddhist

monk who established the Shingon sect.

Back to Shinkansen again, to my speaking engagement at Peace House Hospice – long seen as the premier inpatient unit in Japan. Peace House is a richly endowed unit in a park environment with views of Mt Fuji on good days. We spent several hours there and enjoyed talking to staff. Yukiko Emori was a long term visitor at Gandarra, and is now an ANM there.

Shinkansen to Hiroshima.

The home care service here is remarkably similar to Ballarat Hospice Care and ably managed by Ishiguchi-san with very engaged staff; including a nurse who is keen to become a nurse practitioner.

I was then invited to meet a home care patient. We took a taxi to the hills on the edge of the city, stepped out into light summer rain and onto the doorstep of a small house. I had expected a fragile, damaged person, but the eighty-eight year old woman who bowed and welcomed us was alert, graceful and stylishly dressed.

Her nurse served tea in frail white porcelain cups. A dark blue chain link pattern seemed to lift off the surface of the cup, and it dipped over the edge in a continuity, to fill the cavity. It was the Dome, inverted. The tea was hot and fragrant. Settled, she began.

"It was early in the morning. We had been under great strain for many months, and the planes had been coming over all the time, with the bombs. I was working in the hospital and was in the corridor when it came. I was not hurt because of the concrete wall, but my friend was near a window, and when it happened he was badly injured. I spent a long time helping him. It was my duty. Then we went to the hospital and helped the others. It was so bad. We had so little with which to help, and there were so many."

There was a flash of grief and she was outwardly settled again.

"I never thought I would marry. We were too frightened of what would happen, but I did, and now I have children and grandchildren, and they are alright."

The nurse with whom we had come explains that the fear of producing deformed children was present for everyone and a truth for many. I struggled to ask any question. What to ask that won't cause distress? Finally, panicked by the silence, I asked her how, after such an experience, she had managed to continue to see and create such beauty in the world. She took a browned soft-bound book, and ran a finger down the vertical line of characters - a dedication to her from her friend, and replied obliquely:

"My life has been difficult. I have never since been able to look at the stars."

I'd walked across the road and spent the morning at the Dome, the Peace Park and the museum. By midday my mind was a maelstrom, and nausea made it difficult to be a pleasant

companion at lunch. These events were not ancient history, but had occurred just more than five years before I was born, and had been the subject of occasional talk between my parents and their friends when I was a child. I remembered the explanations, the justifications.

I had bought Kenzaburo Oe's Hiroshima Notes at Changi airport. He refers to the fact that there were 298 doctors in the city at the time of the bombing, and that they and nurses were forbidden to leave the city. He describes the dedication and compassion with which the surviving 28 doctors and 130 nurses cared for the more than 100,000 survivors needing treatment. Most of those who survived the two blasts – the hibakusha – are now dead, but according to the Japanese government, there remain 235,569 living hibakusha as of March 2009. Various writers comment on the fact that they are still subject to significant discrimination.

On neither the sun nor death can man look fixedly, but there are some people who have been forced to do so. Although unable to look at the stars, they have survived with grace. I've had the privilege of meeting one such person.

The speaking engagement at the 15th JSPM was, by comparison, rather anticlimactic. Having been the cause of most of my anxiety before travelling, it seemed quickly done, and eclipsed by a very good lecture by Sam Ahmedzai. Who does his PowerPoint slides?

The trip ended with a reunion lunch. From bento boxes, with all the seven Japanese doctors who had spent time at Gandarra in the past. An end to a memorable foray into a gracious culture.

**David Brumley
Ballarat**

Book Reviews

Cancer Pain from Molecules to Suffering. IASP Press 2010

This clear precise book written by a Panel of International Authorities is a welcome addition to the resources of palliative medicine practitioners. It allows both clinicians and researchers a source of the most current and up to date work ranging from the Basic Mechanisms of Cancer Pain to Psychology of Cancer Pain and Chapters on Interaction, Education and Resources.

Many of the earlier Chapters revise basic mechanisms of pain and unfold to give a rationale to our practice of opioid use and rotation. We get an insight into the latest thoughts on opioid induced hyperalgesia, mechanisms of tolerance and a glimpse of research into drugs that will act against opioid tolerance.

I was particularly drawn to the Chapter by Patrick Mantyh on "Mechanisms of Malignant Bone Pain". I found this a fascinating account of how the development of an animal model of cancer induced bone pain can allow insights into

the various mechanisms involved in the creation of the pain process. The translation of this research into clinical practice was an exhilarating example of the importance of research and its close link to clinical practice. The description of the neuropathic component of cancer induced bone pain has obvious application to our current practice and it is with great interest that we wait on the outcome of trials exploring other strategies at managing malignant bone pain.

For those of us who involved in Clinical Trials there is a very helpful section on Trial Design, both Pharmacological and Non Pharmacological. The Psychology of Cancer Pain was well covered and the Chapter on "Attention Management" by Stephen Morley was the first time I had been exposed to this area of research and practice.

Teaching Palliative Medicine and the management of Cancer Pain specifically is an ongoing challenge for all of us. Forbes and Gibbins in their Chapter on Medical School Education address the issue of teaching in palliative medicine and provide examples of research on how students gain competence and clinical experience.

I finish the review of this excellent resource with a quote from the Chapter by Caraceni titled "Why do Patients Still Suffer." "A recent systematic review showed that while educational interventions can be successful in changing specific aspects of how pain is managed and how care is delivered, it could not be proven that they could change patients' reported pain experiences. The same review showed instead that the provision of care by specialised palliative care services could reduce patients' subjective burden."

Could we ask for a better endorsement of our discipline in such an influential publication?

**Dr Adrian Dabscheck,
Melbourne**

Book Review

Swimming in a Sea of Death – Susan Sontag, serious illness and the limits of hope

Illness is the night-side of life, a more onerous citizenship. Everyone who is born holds dual citizenship, in the kingdom of the well and in the kingdom of the sick. Although we would all prefer to use only the good passport, sooner or later each of us is obliged, at least for a spell, to identify ourselves as citizens of that other place.

Susan Sontag. *Illness as Metaphor*

Susan Sontag was a celebrated American writer and intellectual. In 2004 she was diagnosed with her third malignancy in thirty years. *Swimming in a Sea of Death* is an account written by her son David Reiff of the months leading up to his mother's death.

Hope and the nature of hope are the deep undercurrents of this account. Repeatedly David describes his mother's sense of hope. All hope is filtered through her determination to prevail over her illness.

The foundation stones of this hope were multiple. The first was a sense of exceptionalism borne out of survivorship. The second was a passionate belief in modern medicine. And it was that belief that led her to constantly search for information, trials and physicians that could provide some semblance of a hope for cure or remission. The difficulty, the source of extraordinary intellectual and emotional dissonance, was that information on her disease was appalling. Indeed, that it was "more likely to be undermining than sustaining" and for Sontag to face "the unvarnished reality of her situation would have meant staring without respite into the mouth of the void."

So the exquisite challenge for Sontag was to do the near-impossible and to do it daily for months on end: "to look away and yet feel as if she were not looking away." Reiff expresses this "impossible balancing act" well: "...it was as if she were trying to remain loyal to the idea of the truth and to the supremacy of the factual yet at the same time looking for ways to deny what these facts suggested." That balancing act also involved her son and friends. Throughout those long months she looked to them to agree "that there was a real empirical basis for hope, but also to give her reasons why this should be the case." This led to tortuous interpretations of information: "... I was willfully misinterpreting facts so as to be more able to construe them for my mother if not in an optimistic way, then at least in a less despairing one. ... Reality was elsewhere."

The third foundation for hope was militarism. The patient as soldier, the patient who is willing to endure any suffering in the pursuit of cure.

Sontag believed implacably in this approach.

Redefining hope

Language was Susan Sontag's gift. Language and its power defined her life as a writer and public intellectual. In her illness language became a tool of both struggle and defeat. The meaning of a single word – hope – and the language of hope were, soon after her diagnosis, defined on a most narrow plane – cure or the chance of cure. Hope and the fight to survive were fatally linked. Everything was marshaled towards that goal – every piece of information, usually bleak, every indignity, and they were countless, every conversation with clinicians was predicated on that.

Sadly that was abetted by her doctors. Palliation was addressed professionally but not pressed. There was no discussion beyond statistical chances of survival, details of medications. There is always an illusory mirage of "a chance". "Where there is a chance I will keep fighting" said one Haematologist.

The difficulty with that narrow definition of hope was that, when tested, it collapsed under its own weight. Sontag was like a trapped animal. "Hope" had given her a reprieve in the past. Hope had become a habit. "Hope" so narrowly defined now isolated her and only added to her suffering.

Sadly here, hope was never seen in a broader way. There was no discussion of hope beyond the context of cure or more treatment. Any acknowledgement that there was no hope for cure was closed down. That closing meant that there was no discussion about the multiple other sites of hope that still existed and would continue to do so throughout her illness. The hope that she would be treated to the best of the physicians' ability, the hope that she would not needlessly suffer, the hope that she would always be listened to and the hope that she and her family and friends would have time and opportunity to prepare each other for her death. Comfort, dignity and meaning. There were no end of life plans because end of life was not so much denied as simply not countenanced. Where was the broader discussion of mortality and the dignity of dying? There was simply no search for a good and decent death because, to Susan Sontag, death could never be good or decent. Her son yearned for that, but could never find it, until, tantalizingly, in the very last hours of her life. Hope narrowly defined was a broader hope thwarted.

While death is universal the approach to it never is. Susan Sontag was a remarkable woman who lived her life fully. She was complex, magisterial, driven and engaged. Through the experience of her previous illnesses she had rehearsed her last. She drew lessons from those illnesses. She was true to herself. That truth troubled her son greatly. That truth sought out physicians who offered her active treatment. This account describes the cost of the pursuit of that truth to both mother and son.

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The complete article is available in *The Journal of Palliative Care* (2010) 26:2; 133-134.

Sontag S. *Illness as Metaphor*. Farrar, Stauss & Giroux 1978.

IMJ Submissions

The Internal Medicine Journal is the official journal of the Adult Medicine Division of the Royal Australasian College of Physicians (RACP). The journal publishes original research, brief communications and review articles. This is an excellent forum in which to raise the profile of palliative medicine with clinicians in all fields of internal medicine. I would encourage both consultants and trainees to consider publication in this journal. In the absence of original research, review articles are highly sought after. I would be happy to discuss any potential publications with aspiring authors.

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