

Preparing for the worst, while hoping for the best: An Integrated Palliative Approach in Cardiovascular Disease

The Study of the Particular: Case Study Research Method

Preparing for the worst, while hoping for the best: An Integrated Palliative Approach in Cardiovascular Disease

Palliative care in cardiovascular disease

Cardiovascular disease (CVD) is rapidly becoming the leading cause of death and disability globally, and is also a feature of population ageing.¹ As the number of people experiencing significant disability and dying of cardiovascular disease continues to rise, there is an increasing need to improve end-of-life care. Sadly, research increasingly illustrates that people dying from CVD do not have a 'good death', where the wishes of patients and families are respected within appropriate clinical, cultural and ethical standards, and measures taken to avoid stress and suffering for patients, families and caregivers.

So who should be responsible for end-of life care for people with cardiovascular disease?

Ideally, people with CVD should experience a seamless transition across care settings from primary care to palliative care, but this is not always the case. The reasons for this are multifactorial and relate to system, provider and patient factors. As the number of people dying with chronic conditions escalates, specialist palliative care is not always available, accessible or appropriate. Not only are specialist palliative care services not adequately resourced for this deluge of potential referrals, many patients do not want to be abandoned by physicians, nurses and other clinicians with whom they have established rapport and trust over many years.² Therefore all cardiovascular clinicians need to be prepared to address the physical, social, psychological and existential needs of patients and families from diagnosis to death. To do this requires additional

evidence-based guidelines, education, information dissemination and interdisciplinary, collegial support.³ In particular assistance is required from palliative care clinicians in developing models of care.

So when do we know a palliative approach is appropriate?

Much is written regarding prognostication challenges in CVD and certainly people with heart failure are at higher risk for sudden death compared with the general population.^{4,5} Sudden death remains one of the greatest challenges facing cardiovascular clinicians, not only in relation to therapeutic care but also provision of information, psychological and social support. Failure to prepare the patient and family is often a source of regret for clinicians, and despite increasing use of devices, such as implantable cardiac defibrillators,⁶ death is inevitable.

Many clinicians face the challenge of providing realistic information but wanting to instill hope and motivate and inspire patients and their families.⁷ The unpredictable trajectory of end-stage heart disease further complicates this issue. Yet many malignant conditions, such as breast cancer, have also become chronic conditions and cardiovascular clinicians need to access information on communication and support in oncology for help in these difficult conversations.⁸ These conversations must be carefully planned as not only is the goal to provide people with realistic expectations but also to promote hope, particularly as many chronic conditions depend on self-management strategies.

At end-of-life, people with heart disease may experience a range of physical, psychological and existential emotional symptoms impacting on functional status and diminished

quality of life.^{9,10} Heart failure is the final common pathway for a wide variety of cardiovascular diseases. An increase in the emphasis on a palliative approach should occur when people have severe heart failure with persistent, refractory symptoms at rest and remain classified as New York Heart Association (NYHA) functional class III or IV despite optimal medical therapy.^{11,12} If symptom burden persists or psychological and existential distress is evident, referral to specialist palliative care services is appropriate. Encouragingly, Australia is one of the first countries to include palliative care in the evidence-based guidelines developed by the Cardiac Society of Australia and New Zealand and the National Heart Foundation.¹³

Scepticism and distrust

Many misconceptions surround end-of-life care, often fuelled by the popular press and polarised debates surrounding euthanasia and withholding or withdrawal of treatment.^{14,15,16,17} Clinicians should clearly communicate to patients and families that an increased emphasis on a palliative approach does not mean withdrawal of care but rather augmentation of existing therapies with a focus on symptom relief. A common misconception of palliative care, not only among patients and families but non-palliative care clinicians as well, is the cessation of treatment. In contrast, the CVD therapeutic regimen, both pharmacological and non-pharmacological, becomes more complex during the palliative phase of care.

The need for an integrated palliative approach

An integrated palliative approach requires comprehensive assessment of the patients and families' needs and advance planning by medical, nursing, allied health, social services and family members. Significantly, the goals of palliative care—to improve quality of life, promote psychological and spiritual well-being, improve symptom management, and support family members—are readily reconcilable with CVD management.¹⁸

There is minimal data for managing symptoms at end-of-life for people with CVD. However information and evidence in the management of symptoms causing distress to patients and families, such as dyspnoea, fatigue, constipation, nausea, and psychological and existential issues, can aid treatment options and decisions in both acute care and palliative care settings.^{3,12,19} At end-of-life, clinicians' focus should be on management of the individual and symptoms rather than the physiological

condition. It is also important to remember that the foundation of key heart failure pharmacotherapy strategies, such as angiotensin converting enzyme (ACE) inhibitors, angiotensin receptor blockers (ARBs), beta blockers and aldosterone antagonists, is based on symptom relief and improvement in functional status.¹³ Such medications are therefore an important part of the armamentarium for palliative management to relieve dyspnoea and minimise fluid retention. As physiological functions decline, dose adjustment may be necessary.

When should clinicians increase the focus on a palliative approach?

There are sentinel events or signs that alert clinicians to increase the focus on the palliative rather than the curative approach of CVD management. These sentinel events are often episodes of decompensation accompanied by increasing evidence of debilitation. Using the last period of decompensation is a good opportunity to initiate discussions about end-of-life care.

A way forward?

Many clinicians avoid adequately addressing end-of-life care because of a lack of confidence or perceived lack of knowledge, as well as a desire to protect their patients from distressing information. To address these issues, discussion and debate needs to occur regarding the integration of a palliative approach in CVD management. Many clinicians are increasingly aware of the power of a palliative approach to improve the care of patients and families. We need to develop programs to assist non-palliative care clinicians to integrate a palliative approach. This should occur in undergraduate, postgraduate and professional development settings. We also must reduce the stigma associated with a palliative approach for patients and families. All these solutions depend on a collaborative, interdisciplinary and collegial approach. As chronic diseases, both malignant and non-malignant, increase in prevalence, the need to address these issues is of critical importance in clinical practice, policy and research.

Associate Professor Trish Davidson

Director of the Nursing Research and Chronic Disease Research Unit based in the Western Sydney Area Health Service.

References for this article are available on the CPCRE website www.cpcpre.com (Publications/Centre Line).

The Study Of The Particular: Case Study Research Method



John P. Rosenberg RN
PhD Student
Queensland University of
Technology

Hear the words ‘case study’ and I’m sure you’ll think of the familiar clinical case study technique so often used in education. In selecting a

specific, real life scenario, the teacher attempts to achieve learning goals by providing an issue in its particular context for consideration. However, there is a ‘case study’ approach to conducting research that is quite distinct from the clinical case study.

Description

Like the clinical case study, case study research focuses on a specific case, which might be an individual, a group or an organisation;1 it’s been called the ‘study of the particular’² and has an established place in the social sciences. Case study research is an empirical approach to understanding an existing case within its ‘real-life context’.³

Case study research can be used in three ways:

- The *intrinsic* case study is applied to better understand a particular case for its own sake.
- The *instrumental* case study studies a case in order to understand related phenomena.
- The *collective* case study is an extension of the instrumental case study to several sites in order to promote better understanding and, perhaps, contribute to theoretical development.²

Typically, case study researchers utilise multiple methods to collect and analyse data, and it’s this use of multiple methods that can cause confusion about where case study research fits into the scheme of things. It’s been nicely summarised in this way:

Case studies can use either qualitative and quantitative methods, can be prospective or retrospective, can have an inductive or deductive approach to theory, can focus on one case or many, can describe, explain or evaluate...¹

A case study research project might use, for example, questionnaires, in-depth interviews, focus groups, documentation reviews, artefacts (like photographs),

participant observation, or any combination of these. In other words, case study research is an *approach* to research enquiry rather than a distinct methodology—it tailors specific methods to the context and phenomenon of interest to answer the research questions identified in the genesis of the research enquiry.

Application

Case study research can be useful when:

- The phenomenon of interest is complex and demonstrates multiple interdependent variables that cannot be separated for control.^{2,3}
- Context is central to understanding the case^{3,4,5} and relevance to the clinical setting is essential.¹
- Understanding is optimised by examining the phenomenon of interest from multiple perspectives.¹
- Flexibility in research design is needed and other research designs have limited capacity to answer the research question.¹
- Theory is poorly developed.^{1,2}

Using Multiple Methods

Central to the issue of using multiple methods is a longstanding debate about the *nature of knowing*. The positivist paradigm (which mostly utilises quantitative methodologies) assumes that objective reality exists outside of human perception that’s knowable and measurable, and that highly systematic examination is necessary to test and know the ‘truth’ about the subject under enquiry and identify causality. On the other hand, naturalistic enquiry (which mostly utilises qualitative methodologies) holds that reality is constructed by human perception, is profoundly influenced by context, and may be perceived in many different ways.⁶ Naturalistic researchers maintain that as people’s perceptions of reality are profoundly holistic, individual aspects of human experience can’t be separated from the whole. Consequently, quantitative research has been criticised as reductionist and disconnected from human experience.⁷ In contrast, qualitative research has been criticised as subjective and insufficiently systematic, lacking rigour.⁸

How is it possible to combine multiple methods for case study research when these paradigms seem incompatible? One argument is that any attempt to reconcile these paradigms is futile; instead, the challenge is to understand

data as providing various types of knowledge, seen as ‘different positions on a continuum of knowledge’.^{9,10} Divergent data potentially adds to the complexity of the findings and to the rigour of the study.¹¹ Importantly, others have argued that the choice of methods is a pragmatic one.^{10,12} As the assumptions underpinning each end of the research design continuum are simply different from each other, it’s acceptable to combine apparently incompatible paradigms to attain a more complete answer to the research question.¹² This methodological pluralism has been promoted as a way to *holistic* understanding of the multidimensional and complex nature of human experience, which demands a more diverse means of enquiry that neither quantitative nor qualitative approaches can offer alone.^{10,13} The choice to utilise multiple methods in case study research comes to this—how can the research question best be answered?

Rigour

Like any research, case study research must demonstrate rigour.¹⁴ This may be achieved when:

- Sound theoretical reasoning informs the selection of appropriate methods.
- Methodological rigour is provided by a detailed account of procedural and analytic decisions.
- Interpretive rigour is attained when the researcher’s interpretation of the findings is shown to validly reflect those of the people under study.
- The combining of multiple data sources facilitates a more complete picture of the phenomenon under investigation.¹⁵

Two distinct outcomes of combining multiple sources of data are *confirmation* and *completeness*.^{12,16} *Confirmation* refers to the trustworthiness of multiple observations in identifying the validity of the findings; *completeness* refers to findings that demonstrate the complexity of the phenomena under examination,¹⁶ best described as ‘putting together the pieces of the puzzle’.

Ironically, the complexity in combining data makes

it vulnerable to invalidity—each method must be comprehensively understood, otherwise it may actually increase bias.⁹ To manage this, the research question must be clearly focussed, and the strengths, weaknesses and complementarity of each method must be thoroughly assessed and explained. Some authors¹⁷ have cautioned against the indiscriminate use of multiple methods, advising instead that disciplined, well thought out, and highly managed studies must be devised and implemented.

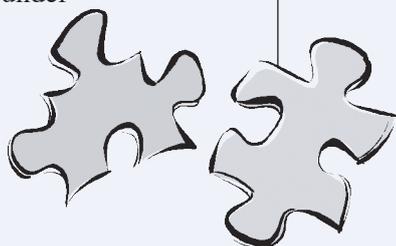
In case study research, rigour can be shown in:³

- **Construct validity:** the changes being studied are measured by the methods employed, particularly through the use of multiple methods, establishing a chain of evidence, and having key informants review the data.
- **Internal validity:** a pattern of outcomes is anticipated and verified by the case study data.
- **External validity:** theoretical, rather than statistical, generalisation takes place in collective case studies when replication occurs that verifies the theoretical proposition.
- **Reliability:** a case study research plan provides a clear record of the operational steps undertaken in the course of the study in the form of an audit trail.

Conclusion

Case study research is specific, highly contextual, flexible and rigorous. It’s especially useful when researchers wish to more completely understand complex, multifaceted phenomena in their real-life contexts where interdependent variables can’t be separated for control, and causality and statistical generalisation aren’t required. In using multiple methods to obtain an holistic perspective of the phenomenon of interest, case study research must be well-designed and highly managed to maintain rigour.

References for this article are available on the CPCRE website www.cpcrc.com (Publications/Centre Line).



CPCRE ACTIVITY REPORT

Developing and Promoting the use of Evidence-Based Resources

Practice Guidelines

A final report, including a summary card, on the management of syringe drivers can be found on the CPCRE website. An on-line education package to support dissemination of the guidelines is also available on the website. (Funded by a grant from Central Zone Management Unit, Queensland Health). A syringe driver workshop to promote uptake of the guidelines was conducted by CPCRE and held at RBWH in April. Further workshops are scheduled—please check the CPCRE Calendar and website.

Systematic Reviews

Indicators of Nausea: A report on a systematic review of indicators and assessment of nausea in advanced cancer is nearing completion. (Funded by a grant from NHMRC).

Critically Appraised Topics

Critically Appraised Topics on topics including the use of opioids for breathlessness, and palliative chemotherapy in advanced colorectal cancer, have been prepared and are available on the CPCRE website.

Paediatric Loss and Grief Information Resources

The newly published information booklet on Paediatric Bereavement can be found on the CPCRE website. (Funded by a grant from Central Zone Management Unit, Queensland Health).

Palliative Approach in Residential Aged-Care Implementation Workshops

A series of 10 skills building workshops is being conducted by CPCRE in collaboration with Aged Care Queensland and the Australian Institute for Care Development. These workshops follow on from the success of the 45 workshops delivered throughout Queensland to facilitate implementation of the “Guidelines for A Palliative Approach in Residential Aged Care.

Promoting access to high quality palliative care education

Palliative Care Curriculum for Undergraduates (PCC4U)

(A joint initiative between Queensland University of Technology, CPCRE, Flinders University and Charles Darwin University; funding from the Department of

Health and Ageing through the National Palliative Care Program). A National Workshop to profile palliative care undergraduate education is being held on 7th June 2006 at QUT. The workshop will include presentations on the outcomes of work undertaken by 10 course providers across medical, nursing and allied health disciplines who have been involved in a project to integrate palliative care in undergraduate health education.

PEPA (Program of Experience in the Palliative Approach): (Funded by the Department of Health and Ageing through the National Palliative Care Program)

PEPA 1: Placements for PEPA 1 have closed. A total of 83 nurses and allied health professionals participated in the Queensland program. Three workshops were held for allied health staff in Cairns and Brisbane. A final report on the program has been submitted, highlighting the positive outcomes of the program for participants, their employers and host sites.

PEPA 2: A total of 72 placements have been offered for GPs, and 20 placements for specialist palliative care staff by June 2006. Follow up post-placement support activities, including a GP Education day have been implemented.

National Coordination Activities: A comprehensive national evaluation of the program has commenced, involving surveys and interviews with participants, employers, host site personnel, mentors and program managers. A final report on the PEPA evaluation is to be submitted to the Department of Health and Ageing in May 2006.

GP Education Program

Five new projects are underway, addressing issues including: knowledge and skill through specialist lead seminars and workshops; strengthening partnerships between GPs and specialist services; improving accessibility to educational resources via an online program with a mentoring component and a video demonstrating insertion of a subcutaneous catheter; and building networks of local GPs interested in developing palliative care services in their district. A one day GP Palliative Care Update workshop was held on 27th May 2006 attended by more than 45 GPs.

CARESOURCES and the Queensland Palliative Care Education Calendar

The 2006 Education Calendar has been distributed to more than 1000 organisations with an interest in palliative care. CARESOURCES, the Queensland Palliative Care Education Directory can be accessed on <www.cpcrc.com>.

CPCRE ACTIVITY REPORT

Allied Health Education

Further workshops are planned in the second half of 2006. Please check the CPCRE Calendar and website for further information.

Paediatric Grief, Loss and Bereavement Education

A booklet entitled "When a Child Dies: A Guide to Working with Bereaved Parents after the Death of a Child" has been prepared by Liz Crowe, BSW. This can be located on the CPCRE website. (Project funded by Central Zone Management Unit, Queensland Health).

Karuna–RBWH–CPCRE Specialist Palliative Care Nursing Education Program

Karuna Hospice Services in collaboration with RBWH and CPCRE is offering a structured education program to four nurses to develop skills in palliative care nursing. The program is funded through the Local Palliative Care Grants program, and involves supported education, mentoring, and clinical experiences in patient and community settings.

Undertaking research

Research programs involving Centre staff address areas including:

- Health services delivery
- Symptom management and supportive care
- Professional Practice Development
- Person-centred palliative care

For further details of specific projects, publications, reports and conference presentations please visit <www.cpcre.com>.

Establishing and facilitating partnerships

Queensland Palliative Care Research Network

The May meeting of the network included discussion of the Network's project which focuses on identifying barriers to best practice in care of the dying. The survey has been distributed to over 300 service providers. Preliminary findings will be presented at the CPCRE Research Conference on June 2nd 2006.

Palliative Care Discussion Forum

Executive members from the three state wide organisations in palliative care in Queensland, CPCRE, Palliative Care Queensland and the Palliative Care Information Service (PCIS), continue to meet to discuss strategies for collaborating in our efforts to advance palliative care in this state.

CPCRE and PCQ are hosting their annual conferences back to back on June 2nd and June 3rd.

Identifying Trends in Palliative Care Service Delivery and their Implications for Queensland

Palliative Care Australia: Quality and Standards Initiatives

CPCRE staff will continue to deliver workshops to promote awareness of the PCA standards. The workshops build on resources developed by PCA. The first workshop was delivered in Mt Isa on May 5th.

Palliative Medications Working Group

CPCRE staff are members of the working group to raise awareness within the primary health care workforce of the PBS listings and to improve community access to and quality use of palliative care medicines. Opportunities to promote this work will be through planned programs as per the CPCRE education calendar. Education sessions have been delivered as part of the Mt Isa Palliative Care Workshop on May 5th, and in the GP Education Day on May 27th.

CPCRE Staff Representative Activities

Acting Director:

- Member: Palliative Care Australia Standards and Quality Committee
- Member: The Cancer Council Australia/Clinical Oncological Society of Australia Medical and Scientific Committee

Director of Learning and Development:

- Member: Steering Committee, Palliative Care Volunteer Project (Caring Communities Project)
- Chairperson: Palliative Care Queensland Education Committee
- Member: Hospital to Home Heart Failure Service Advisory Group
- Member: Palliative Care Working Group, Hospital to Home: Palliation for Sick Hearts Project
- Member: Queensland Working Group for The Supporting Primary Care Providers in Palliative Care Project.

Clinical Research Program Leader:

- Member: QCF Medical and Scientific Committee
- Member: Palliative Care Medications Working Group

Error: In the March 2006 CPCRE Activity Report - Palliative Approach in Residential Aged-Care Implementation Workshops, 'Brisbane South Palliative Care Service' appeared instead of 'Brisbane South Palliative Care Collaborative'. Editor's apologies.

PALLIATIVE PROFILE: BRISBANE SOUTH PALLIATIVE CARE COLLABORATIVE

Brisbane South Palliative Care Collaborative (BSPCC) is a partnership between Brisbane South Palliative Care Service within Queensland Health, Mt Olivet Palliative Care Services and Griffith University School of Medicine. BSPCC's purpose is to help implement best practice clinical partnerships in palliative care service provision, intersectoral research and evidence based palliative care education within Brisbane South. It commenced March 2005 with two years' initial funding. It is directed by A/Prof Liz Reymond, managed by Fiona Israel, Clinical Nurse Consultant (Research) with Ben Sankey (Clinical Nurse) in charge of clinical trials.

Our initial year has been very busy! Firstly, a comprehensive audit and mapping project was conducted to establish strengths and gaps in specialist palliative care service delivery for Brisbane South. This information provides an evidence base to help ensure palliative patients receive best care, at the right time in the environment of their choice.

Secondly, a clinical education and upskilling program is being implemented. This education targets primary health care providers—community nurses, GPs, practice nurses,

indigenous health workers and staff within residential aged care facilities—and attempts to improve networking between generalist and specialist providers.

Thirdly, a research program aimed at improving management of common palliative symptoms has commenced. Ben Sankey is recruiting participants for two randomised controlled trials. One trial's focus is treatment of opioid related constipation; the other explores the usefulness of paracetamol in palliative patients requiring high doses of narcotic analgesics.

BSPCC, with CPCRE, also held a series of state-wide workshops for Indigenous and non-Indigenous aged care facilities to introduce the 'Guidelines for a Palliative Approach in Residential and Aged Care Facilities'.

An exciting recent development for BSPCC has been its successful application to Round 3 of the Local Palliative Care Grants Program. BSPCC, in partnership with Prof Janet Hardy, Aged Care Queensland and the SEA Division of General Practice, will develop, implement and evaluate an end of life care pathway to improve quality of palliative care for residents of aged care facilities in Brisbane South.

Collectively, these initiatives will help advance the discipline of palliative care in SE Queensland—essential to providing quality care to patients, families and communities facing progressive and life limiting illnesses.

PALLIATIVE CARE RESEARCH

Marsden SC, Cabanban CR. Rabies: a significant palliative care issue. *Progress in Palliative Care* 2006; 14(2):62-67.

Rabies patients dying with uncontrolled delirium were identified as a priority by a palliative care team at a Philippines hospital. A study of 45 patients admitted consecutively found that haloperidol was effective in controlling the delirium of rabies. Diazepam was also found to be effective, but with the disadvantage of requiring regular painful IM injections. Patients who previously would have been tied to a bed in a locked room are now able to have care from staff and family to meet their psychosocial as well as physical needs. Their families can also say goodbye—something that was previously impossible.

Rog DJ, Nurmikko TJ, Friede T, Young CA. Randomized, controlled trial of cannabis-based medicine in central pain in multiple sclerosis. *Neurology* 2005; 65(6): 812-9.

This trial in 66 patients with MS and central pain states used cannabis-based medicine (CBM) given via oro-

mucosal spray as an adjunctive analgesic. Patients were able to self-titrate gradually to a ceiling of 48 sprays in 24 hours. CBM was effective in reducing pain and sleep disturbance, and generally well tolerated. However more patients on CBM than on placebo reported somnolence, dry mouth and dizziness. Long-term memory storage was the only cognitive side effect reported.

Maltoni M, Scarpi E, Modonesi C, Passardi A, Calpona S, Turriziana A, et al. A validation study of the WHO analgesic ladder: a two-step vs. three-step strategy. *Support Care Cancer* 2005; 13(11):888-94.

The study aimed to verify whether treatment of mild-moderate chronic cancer pain was more effective going directly from step I to step III of the WHO analgesic ladder, than using the traditional three step process. Fifty-four patients were randomised to the study and their pain intensity assessed over 2649 days. The new strategy showed a statistically significant benefit over the traditional approach in percentage of days with worst pain. A greater incidence of significant anorexia and constipation was reported in the new strategy arm, where prophylactic laxative therapy was used less, so although a direct move to the third step of the WHO ladder was deemed feasible and could reduce pain scores, careful management of side effects is necessary.

FORTHCOMING EVENTS 2006

Queensland

2 June 2006

CPCRE Annual Research Conference.
Royal Brisbane & Women's Hospital,
Education Centre
Enquiries: (07) 3636 1449
cpcrc@health.qld.gov.au
www.cpcrc.com

2-3 June 2006

Friday night CPCRE/PCQ dinner and
All-day Saturday PCQ Annual Conference.
Research into Practice—Evidence at the
Bed Side.
Enquiries: (07) 3633 0096

National

24-25 August 2006

Western Australia State Palliative Care
Conference.
Beyond the Picket Fence: Expanding the
Boundaries of Palliative Care.
Enquiries: j.hale@ecu.edu.au

8-9 September 2006

The Inaugural Palliative Care Nurses Australia
Conference, 'Strength in Working Together.'
Melbourne, Australia
sharni.randall@med.monash.edu.au

4-6 October 2006

Australian and New Zealand Society of
Palliative Medicine (ANZSPM) Conference.
Newcastle, Australia
www.anzspm.org.au

International

31 May-1 June 2006

5th Annual Kaleidoscope Conference.
Benchmarks and Milestones: Striving in
Education for Excellence in Palliative Care.
Dublin, Ireland
www.sfh.ie/education

8-12 July 2006

UICC World Cancer Congress 2006
Bridging the Gap, Transforming Knowledge
into Action.
Washington DC, USA
www.worldcancercongress.org

7 October 2006

World Hospice and Palliative Care Day

26-28 October 2006

The 17th Hospice New Zealand Palliative Care
and New Zealand Pain Society.
Dunedin, New Zealand
www.hospice.org.nz

16-19 November 2006

2nd African Congress on Pain.
African Federation for the Study of Pain.
Tipoli, Libya
www.pain-free-africa.co

ONLINE EDUCATION AND PUBLICATIONS

The online education activity—on the CPCRE web site—associated with the "Guidelines for Syringe Driver Management in Palliative Care", requires a username and password, purely to meet the requirements of the QUT site where the website is hosted. For a username and password, simply email <cpcrc@health.qld.gov.au>.

The Guidelines, as well as the new publication "When a Child Dies: A Guide to Working with Bereaved Parents after the Death of a Child from Illness", can be downloaded from the website 'Publications' page, and small numbers are able to be mailed out.

STOP PRESS

PEPA will continue! The Department of Health and Ageing has recently confirmed that funding has been allocated in the federal budget and PEPA will continue to be offered after June 2006. For more information about opportunities to gain experience in caring for people with life limiting illness please see our website <www.cpcrc.com>.

CENTRE LINE

June 2006 Newsletter of the Centre for Palliative Care Research and Education Vol. 2 No. 2

Acting Centre Director /Director of Research

Professor Patsy Yates Ph: (07) 3636 1449

Director of Learning and Development

Deborah Prior, PhD Ph: (07) 3636 1337

Clinical Research Program Leader

Professor Janet Hardy Ph: (07) 3636 1449

Administrative Officer

Alannah Gaffney Ph: (07) 3636 1449

Project Manager National Co-ordination / Evaluation - PEPA

Linda Barrett Ph: (07) 3636 8197

PEPA 2 (QLD) Project Manager

Helen McKeering Ph: (07) 3636 6216

Research Officers

Diane Maresco-Pennisi, PhD Ph: (07) 3864 8205
John Haberecht Ph: (07) 3636 5251

General Enquiries

Ph: (07) 3636 1449 Fax: (07) 3636 7942

Email: cpcrc@health.qld.gov.au Website: www.cpcrc.com

Postal Address

Centre for Palliative Care
Research and Education
Royal Brisbane & Women's Hospital
Post Office Herston QLD 4029

Street Address

Block 7/Level 7
Royal Brisbane & Women's Hospital
Herston Road
Herston QLD 4029

The Centre

The Centre for Palliative Care Research and Education is an initiative of Queensland Health and is a collaboration of the Royal Brisbane and Women's Hospital and Health Service District, The Prince Charles Hospital and Health Service, Queensland University of Technology, Karuna Hospice Inc., and the Queensland Divisions of General Practice.

Disclaimer: The views or opinions expressed in any Centre Line articles or inserts are not necessarily those of Queensland Health or the Centre for Palliative Care Research and Education. While all precautions have been taken to ensure the quality of information provided, this information has been provided in good faith and, as such, the CPCRE cannot guarantee the accuracy or currency of the content displayed. Use of any Website and its information is at the risk of the individual user, and CPCRE shall not be responsible for any losses or damages that may result. Hypertext links to other sites do not mean that CPCRE endorses those sites or the materials contained on them.