

## Non-malignant Palliative Care

- **For chronic, acute or end-stage renal disease patients, palliation is a treatment option.**
- **Evidence highlights the need for novel, tailored and flexible models of care for the unique care requirements associated with Motor Neurone Disease, Multiple Sclerosis, Parkinson's Disease and Huntington's Disease.**

This issue of *Centre Line* features non-malignant palliative care in recognition of the large number of patients—and their carers—in hospital and community settings affected by diseases other than cancer. Our feature articles and service profile present a sample of non-malignant illnesses and supports available for this population.

### Princess Alexandra Hospital Renal Unit

Brisbane's Princess Alexandra Hospital (PAH) Renal Unit provides care to several thousand patients with chronic, acute or (irreversible) end-stage renal disease (ESRD) throughout Queensland and interstate.

ESRD describes patients with less than 10% renal function. Chronic Renal Failure (CRF) is generally characterised by sub-optimal renal function, but over 10%. Patients with Acute Renal Failure (ARF) may experience improvement in renal function or progress to ESRD.

The incidence of renal disease is increasing, resulting in a significant increase in referrals to PAH Renal Unit. The unit's non-transplant patients are predominantly from Brisbane South, West Moreton, Redlands and Logan areas. Transplant patients are drawn from much further afield, as the unit is the sole Queensland provider of renal transplant surgery. After transplant, patients are managed by regional nephrologists and only referred back to PAH if complications arise.

### Options and Pathways

Patients with ESRD require dialysis or transplantation for survival. Patients with CRF may never need dialysis, but if it becomes a treatment option, the decision is theirs. Patients already receiving dialysis, likewise, can choose to continue or cease dialysis. A thorough medical, psychiatric and psychosocial assessment of the patient

occurs if cessation is requested by the patient or family.

Irrespective of the patient's wishes, dialysis is decreasingly viable when patients exhaust their dialysis access measures. Transplant complications including lymphomas, infections and rejection may result in loss of the transplanted kidney, resulting in a return to dialysis or eventual death. **Hence, within all of these patient categories, palliation is a treatment option.**

### Palliative Care and the PAH Renal Patient

Most CRF patients nearing ESRD choose to commence dialysis or undergo a renal transplant. Most patients on dialysis choose to continue dialysis or, if they meet transplant criteria and a donor organ is available, accept an offer of a donor kidney.

In the time since renal treatments began at PAH in the late 1960s, many patients have opted not to proceed with ongoing, long term and more invasive treatments either through choice or necessity. This has created a need for palliative treatment services.

Throughout the history of the PAH Renal Unit, care has always been provided to the minority of patients who elect not to commence or to withdraw from treatment.

In recent years, criteria for accepting patients onto the dialysis program have become more liberal. This, combined with a reduced proportion of ESRD patients eligible for transplantation and a low community donor rate, has led to a CRF and ESRD patient population that is older, sicker, and more likely to include co-morbid patients. Because of this development, withdrawal from or non-commencement of dialysis and associated palliative care is increasingly incorporated as an appropriate treatment pathway, threading across a broad range of patient and treatment scenarios.

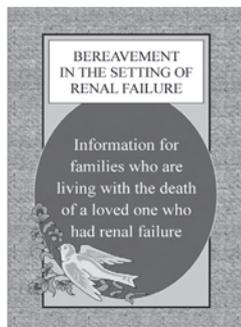
## Bereavement Care and Palliative Services for Renal Patients at PAH

A 2002 review of services to bereaved families of PAH Renal Unit patients led to many changes. Protocols were established regarding condolence cards and a brochure was designed describing grief and loss processes in the renal setting, and hospital and community bereavement supports. A Nephrology Memorial Service held at PAH attracted nearly 200 family members of deceased renal patients.

In 2003 the bereavement theme was extended to embrace the growing need for integrated palliative care protocols and practices. A working party of renal nurses, social workers and a medical consultant addressed this need.

The working party outcomes included the following:

- Implementation of a 10-step “*Withdrawal of Patient from Dialysis*” Clinical Pathway Protocol;
- Creation of a renal palliative care brochure for patients ceasing treatment through choice or emerging medical circumstances;
- Creation of a palliative care wall poster explaining processes and support services that was then displayed in patient and family areas on the ward;
- Strengthening of linkages with PAH Palliative Care Service, enabling better awareness of community palliative care services for patient referral;
- Creation of a staff palliative care manual with journal articles and renal-specific care procedures for issues such as itch, altered taste and pulmonary oedema;
- Provision of portable beds for family members wishing to remain near their loved ones during the terminal phase.



Renal Bereavement Brochure

PAH Renal Unit's palliative care service is for patients known to the Unit who have received dialysis and/or transplantation. Treatment ranges from months to over 30 years living with ESRD. Patient ages range from the mid thirties to 80 years.

The decision to withdraw from dialysis is often related to health issues associated with or compounded by co-morbidities including insulin dependent diabetes mellitus, ischaemic heart disease, limb amputation, chronic leg ulcers caused by renal related calciphylaxis, and peripheral vascular disease. There is a common patient history of complex medical problems and arduous treatment processes—often tempered by a human spirit of determination, courage, tenacity and good grace.

## The Renal Palliative Experience

The provision of palliative care to patients throughout the renal treatment spectrum has always been integral.

While no research has been conducted on the Renal Unit's palliative service, staff have designed a brief questionnaire for patients and families admitted to the ward for palliation.

The following identified factors are particularly relevant to palliative care of renal patients:

1. The patient and family have often been known to renal unit staff (medical, nursing and allied health) for many years. Providing palliative care is the end stage of a treatment process that may have spanned many years. The patient-staff relationship is, therefore, different but remains professional.
2. Patients may hope or expect to receive palliative care on the renal ward. This can present significant problems as there are never enough beds in this acute ward in a tertiary hospital. The ward design does not lend itself to palliative care, although every effort is made to ensure maximum dignity and best palliative care practice. Patients can become very disappointed if unable to be nursed within the ward environment they often refer to as a second home.
3. Issues relevant to renal failure include management of fluid balance, uraemia, itch and altered taste, as well as providing adequate pain relief.
4. The palliative phase of renal care can be a mixed blessing; relief from suffering and pain is in sight but also impending separation from those closest to them. Families may naturally have difficulty with separation and closure.
5. Patients and families must adapt to moving from a tight dietary regimen to one where the patient can eat and drink freely. Support is often required to help patients and families feel comfortable about this when dietary restrictions have been long standing.
6. Various medical problems, including dialysis access issues and major infection, can trigger the decision to withdraw from dialysis. Renal failure causes and is part of wider systemic problems. Solid information to patients and families assists their understanding of what can go wrong and why—helping them participate in care and treatment decisions.

In the context of renal disease with its propensity for multitudinous complications and the associated tendency for patients to lose their sense of autonomy in the process, excellent care at all levels, especially that of palliation, is becoming more vital than ever.

This is an edited version of an original document by Linda Smith (Clinical Nurse) and Catherine Martin (Social Worker) Princess Alexandra Hospital Renal Unit, Brisbane, February 2006.

# Assessment of the Supportive and Palliative Care Needs of People with Neurodegenerative Disorders



Dr Samar Aoun

A 2002/03 Australian study assessed the supportive and palliative care needs of patients or carers of patients with the following neurodegenerative disorders: Motor Neurone Disease (MND), Multiple Sclerosis (MS), Parkinson's Disease (PD) and Huntington's Disease (HD).

As these diseases are incurable, progressive, life-limiting and cause long periods of dependency, those who live with them face many long-term challenges. While evidence suggests this patient population and their carers have extensive supportive care needs, little was known before this study of how they perceive those needs.

The study aimed to 1) identify the needs of patients with the four neurodegenerative disorders and their carers for supportive care/palliative care services and 2) determine the extent to which existing models meet these needs in terms of service delivery, accessibility and utilisation.

Phase 1 of the study in 2002 involved interviews with 130 patients, carers and service providers. Phase 2 (2003) consisted of a national survey of 503 patients and 373 carers from Western Australia, Victoria and Queensland.

Seven main themes from Phase 1 reflect the process that patients and carers encounter as they cope with the impact of the diseases, illustrating their supportive care needs.

The themes are adjusting to the impact of the disease; searching for essential information; gathering practical support from many sources; bolstering the spirit; organising individual care; fearing the future; and getting the message across.

In Phase 2, tasks that patients reported needing most assistance with were transport for appointments or shopping; housekeeping; financial matters; and attending social activities or support groups.

Many patients reported they did not need high-level assistance with personal tasks within their home environment. They were more likely to report more

assistance was needed in accessing community activities and performing administrative tasks (e.g. financial matters).

The services most frequently received by patients and carers were community rehabilitation, home care and respite.

Disease information, equipment for daily living, dependable support workers and financial assistance for care were rated by both carers and patients as being highly important in helping them manage.

Overall, patients reported moderate–high levels of satisfaction with the following aspects of service provision: privacy during health care provision; involvement in decision making about their care; information about care and support services; availability of health care workers; and clear explanations of their condition and progress. About half of all patients reported being less satisfied with the opportunity to address social and spiritual issues of concern.

Carers reported they were least satisfied with psychosocial care, availability of respite, family conferences held to discuss condition, and pain management information.

Apart from raising issues of financial assistance, access to equipment, home care, and respite and allied health services, many carers acknowledged that caring at home depended on their ability to cope physically and mentally with the role.

Many patients and carers reported that their greatest assistance came from support groups and organisations, but lack of funding was undermining the capacity of such groups to address the needs of all sufferers, particularly people living in rural areas who had a greater disadvantage.

Both patients and carers identified the following as being least helpful: the perceived lack of empathy, interest and communication skills of specialists; lack of knowledge about the conditions by hospital staff; and delays in diagnosis.

The survey findings indicated that as dependency increased and more support was needed, both patients and carers exhibited higher distress symptoms and poorer quality of life. Moreover, many respondents were yet to deal with end-of-life issues, as most were still in the early stages of disease.

The frequency of use of palliative care services for the entire sample was quite low. This probably related to early disease stage, patient reluctance to accept palliative care, or difficulty accessing it.

*Continued next page*

However, those identified as having MND reported receiving at least twice as many palliative care services as the other groups. Carers most satisfied with palliative care services were in the MND and PD group. It is possible they had received more tailored services, as they frequently mentioned a PD specialist nurse and a special MND program. Patients and carers in these groups may also be more accepting of the palliative care approach.

Prior to this study, no previous collaborative study of this scale had been undertaken in Australia. In all, there were over 800 participants spread geographically over three states, with a rural/urban mix and consisting of patients, carers and service providers of four neurodegenerative disorders.

This study provides the first empirical evidence of the needs and service use of these neurodegenerative groups, and will form the basis for future developments of palliative and supportive care services for people with these four conditions. It has also laid the foundations for subsequent evaluation of service provision to this community.

The evidence highlights the need for novel, tailored and flexible models of care for the unique care requirements associated with MND, MS, PD and HD.

*Edited version of an original article by  
Dr Samar Aoun*

*Associate Professor*

*WA Centre for Cancer and Palliative Care*

*Edith Cowan University*

### **Further Reading:**

The following three articles will present results from the featured study.

Aoun S, Kristjanson L, Yates P. Palliative and supportive care needs of people with neurodegenerative conditions and their families: An Australian survey. In Press in *Journal of Palliative Care* 2006.

Aoun S, Kristjanson L, Oldham L. The challenges and unmet needs of people with neurodegenerative conditions and their carers. *ACCNS Journal for Community Nurses* 2006;11(1)April (in press).

Kristjanson L, Aoun S, Oldham L. Supportive and palliative care needs of individuals with neurodegenerative conditions and their family carers. In Press in *International Journal of Palliative Nursing* 2006.

## **Palliative Care Nurses Australia (PCNA) Representing Nurses in Palliative Care**

At the 2005 National Palliative Care Conference in Sydney, Professor Linda Kristjanson (Professor of Palliative Care, Edith Cowan University) launched Palliative Care Nurses Australia (PCNA).

PCNA membership is open to all nurses who work or are interested in palliative care. It will be a national voice for palliative care nursing and foster links with other nursing specialty fields. It will also provide members with an opportunity to promote and support palliative care as their clinical specialty. A representative from PCNA will sit on the Council of Palliative Care Australia (PCA).

According to interim Chair of PCNA, Professor Margaret O'Connor (Vivian Bullwinkel Chair in Palliative Care, Monash University), "there had been significant interest over a number of years from nurses working in palliative care to form a national group."

### **The Formation of PCNA**

The development of PCNA began at the 2003 National Palliative Care Conference, where palliative care nurses met to discuss forming a national group. PCA voiced support for a group to provide a single national voice for palliative care nurses. This meeting resulted in the formation of a working group and, subsequently, a smaller steering committee.

With much hard work, the steering committee established PCNA's foundations including its name, incorporation, memoranda of understanding with other organisations, strategic plan, link on the PCA website, and plans for a conference.

The steering committee then became the Interim Committee with Professor O'Connor as interim Chair.

### **The PCNA Inaugural Conference**

The PCNA inaugural National Conference entitled 'Strength in working together' will be held in Melbourne 8-9 September 2006 at the recently refurbished Hotel Y.

The conference will focus on the following themes: collaborative approaches, clinical initiatives, innovative care settings and policy and service delivery. Elections for PCNA Committee and Chairperson will occur during the conference at the first Annual General Meeting.

Professor O'Connor believes the Conference will be "a unique opportunity for palliative care nurses and nurses with an interest in palliative care to come together to learn, exchange ideas and collaborate."

For further information about PCNA, its inaugural Conference or membership, visit [www.pallcare.org.au](http://www.pallcare.org.au) or email [pcna@pallcare.org.au](mailto:pcna@pallcare.org.au)

## CPCRE ACTIVITY REPORT

### Developing and Promoting the use of Evidence-Based Resources

#### Practice Guidelines

A final report on the management of syringe drivers, which includes a summary card, can be found on the CPCRE website. The guidelines have been developed in collaboration with an Expert Advisory Group.

An on-line education package to support dissemination of the guidelines is currently being developed. (Funded by grant from Central Zone Management Unit, Queensland Health).

#### Communication in Palliative Care

Literature reviews have identified articles which are currently being reviewed. (Funded by grant from Central Zone Management Unit, Queensland Health).

#### 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 (CATs) on subjects including the use of opioids for breathlessness, and palliative chemotherapy in advanced colorectal cancer, have been prepared. Future CATs will address topics such as depression in palliative care and education of health professionals. These will be available on the CPCRE website.

#### Paediatric Loss and Grief Information Resources

An information booklet on Paediatric Bereavement has recently been published. To view the booklet, visit the CPCRE Website. (Funded by grant from Central Zone Management Unit, Queensland Health).

#### Palliative Approach in Residential Aged-Care Implementation Workshops

(Funded by Palliative Care Australia through the Department of Health and Ageing's National Palliative Care Strategy). CPCRE and Queensland University of Technology, in collaboration with Brisbane South Palliative Care Collaborative, delivered a series of 45 workshops 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 pilot project to implement palliative care in nine undergraduate courses across Australia is underway. A National Workshop to profile palliative care undergraduate education is being scheduled for June 2006.

#### 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 clinical placements as part of the Queensland program. Three workshops were held for allied health staff in Cairns and Brisbane.

**PEPA 2:** A total of 72 placements will be offered for GPs, and 20 placements for specialist palliative care staff by June 2006. More than 31 placements have been completed to date. Further information about the program can be found on the CPCRE Website.

#### 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 due to be submitted to the Department of Health and Ageing in May 2006.

#### GP Education Program

Five new projects have been funded for the 2005/2006 round. These projects address 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 on-line 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 is being scheduled for May 27th 2006. Further information can be found on the CPCRE website.

## CPCRE ACTIVITY REPORT

### 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](http://www.cpcrc.com)>.

### Allied Health Education

The third workshop in the allied health series was held in Brisbane in February 2006. This was attended by more than 36 participants from a variety of disciplines.

### 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. When completed this booklet will be available on the CPCRE website and from CPCRE. (Project funded by Central Zone Management Unit, Queensland Health).

### 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.cpcrc.com](http://www.cpcrc.com)>.

### Establishing and facilitating partnerships

#### Queensland Palliative Care Research Network

The March meeting of the network included a presentation by Geoff Mitchell on Individualised Medication Effectiveness Test (IMET) study designs. The network continues to develop its survey tool for its collaborative project to assess barriers to best practice in care of the dying; distribution of the survey is planned for May 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.

### 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 promoting awareness of the PCA standards. The workshops build on resources developed by PCA. The first workshop is scheduled for Mt Isa in May.

#### 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.

#### 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: 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

## PALLIATIVE PROFILE: MOTOR NEURONE DISEASE ASSOCIATION OF QUEENSLAND



MNDAQ, Inala

The Motor Neurone Disease Association of Queensland Inc (MNDAQ) has been representing people with Motor Neurone Disease (MND) and their carers since 1983. Its primary focus is to provide information and support to people with MND and their carers.

MNDAQ disseminates brochures and booklets about MND, covering topics such as symptoms, diagnosis, treatment and support services. In its publicly available information kit, MNDAQ has personal accounts of carers and extensive information about services, supports, and Brisbane City Council's disability and access information service. The kit also contains details of the Australian Motor Neurone Disease Registry and encourages those with the illness to participate.

MNDAQ support includes equipment available for loan to people with MND, the only cost being a fully-refundable bond. MNDAQ has support groups in the Gold Coast, Sunshine Coast, Darling Downs, North Brisbane, and Caboolture areas. These groups, which are run by volunteers, offer mutual

support and information exchange opportunities for people with MND, carers, friends and family, in addition to raising community awareness about the disease.

Lesley Taylor, Office Manager at MNDAQ's premises in Wedgetail Street, Inala, is assisted in her support of the association's members by many volunteers and by Jim Ferguson as equipment officer. Lesley regularly attends the MND clinic at Royal Brisbane Hospital but emphasises that her role is not clinical. She says she is there "more to be a support for the patients and their carers...some of them are like old friends".

MNDAQ relies largely on individual donations and fundraising, and has received grants from the Gambling Community Benefit Fund and Jupiters Casino Benefit Fund. The support groups also raise funds for research and practical support.

Regular meetings are held at the office, which has full wheelchair access. Membership is open to all and costs \$20 per year, which includes the two monthly newsletter. People with MND pay \$5 per year which includes membership and the newsletter.

Office hours for MNDAQ are generally Wednesday to Friday, 9am–5pm, but it is advisable to telephone before visiting to make sure someone will be there.

*Phone 07 3372 9004 Email mndaq@tpg.com.au*

## PALLIATIVE CARE RESEARCH

**Elman LB, Dubin RM, Kelley M, McCluskey L. Management of oropharyngeal and tracheobronchial secretions in patients with neurologic disease. *J Palliat Med* 2005; 8(6):1150-1159.**

The authors review anatomy and physiology relevant to excessive oropharyngeal and tracheobronchial secretions along with the available medical, surgical and physical therapies. They assess current management and supporting literature, concluding there are many effective therapeutic options from which to choose, such as drugs, physical therapies, surgery and radiation. A comprehensive table of drugs used to manage secretions detailing form, dosage and side effects is included.

**Fayers PM, Hjermsstad MJ, Ranhoff AH, et al. Which Mini-Mental State Exam items can be used to screen for delirium and cognitive impairment? *J Pain and Symptom Manage* 2005; 30(1):41-50.**

Cognitive impairment, common in palliative care patients, is frequently undetected, with the consequence that psychiatric states such as delirium are inadequately treated. The authors explore the use of a short and simple questionnaire to screen for cognitive impairment. They

determine that using only four of the original 20 MMSE items provided a fair degree of accuracy, while using a six-item questionnaire greatly improved the screen's sensitivity.

**Grbich C, Maddocks I, Parker D et al. Identification of patients with noncancer diseases for palliative care services. *Palliative and Supportive Care* 2005; 3:5-14.**

This study identifies criteria to measure the eligibility of patients with end-stage, noncancer diseases for palliative care services in Australian residential aged-care facilities. In the absence of validated guidelines, the following five instruments were used:

- The American National Hospice Association (NHA) Guidelines (adapted version);
- The Karnofsky Performance Scale (adapted version);
- The Modified Barthel Index;
- The Abbey Pain Score (for the assessment of people unable to verbalise)
- A Verbal Descriptor Scale (for pain measurement).

The adapted NHA Guidelines provided an initial indicative framework and the other instruments assisted in providing confirmatory data for service eligibility.

## FORTHCOMING EVENTS 2006

### Queensland

#### 4–5 May 2006

Update in Palliative Care/  
Syringe Driver Workshop.  
Mt Isa  
Enquiries: (07) 3636 1449

#### 25 May 2006

PCQ Breakfast Seminar.  
Contemporary Approaches  
to Bereavement Care.  
Ms Sally Wall  
QCF Auditorium  
Enquiries: (07) 3633 0096

#### 27 May 2006

CPCRE Update in Palliative Care  
for GPs, Practice Nurses and other  
Primary Care Providers.  
Brisbane  
Enquiries: (07) 3636 1449

#### 2 June 2006

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

#### 21–27 May 2006

**National Palliative Care Week**

#### 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

#### 23–25 April 2006

16th Annual Provincial Conference on  
Palliative and End-of-Life Care.  
Toronto, Canada  
www.palliativecare.humber.ca

#### 25–27 May 2006

4th Research Forum of the European  
Association for Palliative Care.  
Collaborate to Catalyse Research.  
Venice, Italy  
Presentations in English  
www.eapcnet.org

#### 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

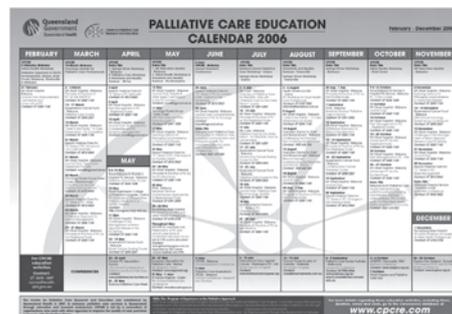
#### 16–19 November 2006

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

## CPCRE Calendar Now Available

CPCRE's poster size 2006 Education Calendar  
has been distributed and is also downloadable  
in A4 size from the centre's web site:  
[www.cpcr.com](http://www.cpcr.com)

If you would like more copies, please  
contact the centre on 07 3636 1449 or email  
cpcr@health.qld.gov.au



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March 2006 Newsletter of the Centre for Palliative Care Research and Education Vol. 2 No. 1

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### 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.

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