VPMTP

VICTORIAN
PALLIATIVE MEDICINE
TRAINING PROGRAM

Victorian Regional/Rural Project in Palliative Care

Final Report: February 2015

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Acknowledgements

Many people have participated in the Victorian Rural /Regional project in palliative care. In particular:

- Riki Long for conducting the project that included designing, implementing and writing the report.

- VPMTP project oversight group at the Centre for Palliative Care, St. Vincent's Hospital Melbourne: Dr Leonard Scicutella, VPMTP Medical Coordinator; Associate Professor Mark Boughey, Director of Palliative Medicine and Deputy Director of the Centre for Palliative Care; Associate Professor Jennifer Philip, Deputy Director of Palliative Medicine; Ms Soula Ganiatsas, Head of Operations; Ms Aurelia Ginevra, Administration Officer VPMTP and Dr. Jane Fischer, Chief Executive Officer/Medical Director, Calvary Healthcare Bethlehem for their support, expert advice and feedback during the project.

- Regional/rural Palliative Care Services in Victoria for their support, willingness to engage and valuable contributions to this research report.

Executive Summary

The Victorian Regional/Rural Project in Palliative Care (VRRPPC) was undertaken to:

1. To identify and describe the professional and social supports needed to successfully attract and retain Palliative Medicine specialists to live and work in regional areas.
2. To explore new models of supervision and training in regional centres to encourage the building of a regional workforce.

This report is a summary of the findings and represents the final deliverable for the project.

From an analysis of recent medical workforce planning data from Victoria it has been identified that that there are insufficient Palliative Medicine specialists currently practising in regional/rural Victoria to meet current service needs for an ageing population and for the future expansion of services in these areas. The shortfall of Palliative Medicine specialists in rural areas also has implications for the supervision of advanced trainees that involves specialist supervision as a part of their training requirement. Creating a sustainable rural palliative medicine workforce requires attention to ongoing supply as well as the issues that affect recruitment and retention.

Palliative care services operate across a variety of settings with community-based services, designated inpatient beds, acute hospital based consultancy services and hospice. The role of the Palliative Medicine specialist includes the direct care of patients with life-limiting complex conditions, consultancy and advice to general practitioners and other medical specialists, support and supervision to multidisciplinary team members, research and education.

Vision

The vision for palliative care services in rural Victoria is to ensure that all Victorians with a life-limiting illness experiencing increasingly 'complex' symptoms have access to high-level specialist palliative medicine services that is responsive to their needs.

Challenges

This document identifies and responds to the number of challenges (professional and social) experienced by rural Palliative Medicine specialists and the health services in which they are employed.

Specifically the challenges are:

- Attracting and retaining Palliative Medicine specialists to practice in rural regions
- A critical mass of specialists to support practice and advanced trainee needs
- Disparate health service personnel support and acceptance of the role
- Lack of community awareness of the benefits of the role
- Strengthening palliative care health service frameworks to support the role
- Resource and environmental challenges affecting role implementation
- Training opportunities for advanced palliative medicine trainees in rural regions

Responding to the Challenges

The two phases of this project, a review of the literature and interviews with key stakeholders (Palliative Medicine specialists and those involved in the management of palliative care services) in the five key regions (Barwon South Western, Grampians, Loddon Mallee, Hume & Gippsland) of rural Victoria provide evidence for the use of a multifaceted approach that gives due consideration to the professional, personal and environmental context in which care is delivered. In order to meet the changing and complex needs of people with a life-limiting illness it is important that palliative care frameworks of practice clearly support the Palliative Medicine specialist role in caring for people across different settings to meet patient needs over the illness trajectory.

Project Findings: Key attributes of Successful Regional/Rural Models of Palliative Medicine Practice

It is recognised that there are a number of elements that influence Palliative Medicine specialists to practice in regional/rural areas. Key attributes of successful regional/rural models include consideration to the professional and personal needs of the specialist at a number of levels.

- **Individual level:** attention to rural background/intent; ensuring positive rural exposure in medical training; flexible work contracts that include adequate incentives; professional support that enhances autonomy and the use of a variety of skills in practice; peer and collegial support; professional development opportunities through links with metropolitan centres; and social support to meet family needs, especially spouse/partner employment and community integration are highlighted as central factors influencing job satisfaction and retention.
- **Workplace level:** strong health service leadership, management support, and practice recognition; well-developed strategic plans for specialist palliative care delivery; attachment to metro tertiary health services; working within multidisciplinary palliative care teams and frameworks that interconnect community, hospital and hospice services provide ideal environments for sustaining specialist practice.

Key Recommendations

The following recommendations are suggested to enhance attraction to and sustainability of specialist palliative medicine practice in rural Victoria acknowledging the influence of employing regional Health Service processes, Victorian Palliative Medicine Training Program (VPMTP) role in prevocational and vocational training outcomes and Department of Health, Policy and Funding implementation strategies.

Palliative Medicine Specialist Workforce Requirements

- A minimum of 2 resident Palliative Medicine specialists (EFTs as demand requires) in all five regions of Victoria to enable sharing of practice responsibilities, on-call and leave.
- Consideration to flexible work arrangements by health services to enable practice sharing within a region. For example:

  *Shared clinical roles between metro/rural,
  *Joint clinical/academic appointments with a University
  *Joint clinical roles (i.e. oncology/geriatrics and palliative medicine)

- Adequate supervision /mentoring of junior specialists are essential in rural Victoria and may require input from other centres.
- Explicit position description that include bundles of incentives (e.g. flexible family-friendly practice, competitive salary package) that clearly articulate roles responsibilities and processes in place for role implementation and support.

- Increased presence/role of Palliative Medicine specialist across settings (i.e. in the community and in key regional hospitals) to build collegial relationships. This is also important for early referral, optimal patient care to meet complex care needs and for appropriately supported patient discharge needs.
- Education and support for dedicated use of telehealth practices to assist remote palliative medicine care delivery and facilitate multidisciplinary approaches to care.

Health Service Requirements

- A trained and skilled multidisciplinary team of professionals that work together to optimise patient care outcomes is the cornerstone of a comprehensive palliative care service. Support given for regional capability to up-skill (GPs, nursing, allied and mental health care staff across settings) is an effective solution to address shortage and support specialist palliative medicine practice. A process that enhances team structures in regions and supports ongoing professional development needs of these disciplines is essential.
- Infrastructure support and education for routine use of telehealth to support practice roles and to facilitate team meetings.
- Data collection frameworks (monitoring and evaluation) to support evidence-based specialist palliative medicine practice.

Palliative Medicine Specialist Training Requirements

- It is essential the VPMTP in conjunction with the Chapter of Palliative Medicine at the RACP commence discussions to develop further flexible and accredited clinical supervision and mentorship models for advanced palliative medicine trainees in regional/rural health services

- A greater focus of rural palliative medicine practice in the curriculum of the VPMTP will enhance potential graduate choice of practice in rural locations. Building, lengthening rural rotations, mandating rural placement (e.g. in training terms 4 or 6) and providing greater opportunities for distance education through development of wider modalities of learning (e.g. videoconference, web-based learning systems) are strategies that will provide greater exposure to rural practice and provide rural doctors opportunities for specialist qualification

- Targeted selection of general medical practitioners/physicians in rural areas (e.g. areas without a resident specialist) with an interest in palliative care who may wish to consider specialist or diploma qualification, with adequate support/incentives in place to do so and where support for training can be provided locally in addition to metropolitan training requisites of the training program is a strategy that needs consideration. A professional bundle of incentives to assist this process that includes back-up support for study leave is important to ensure the benefits outweigh the opportunity cost.

List of Acronyms

AChPM	Australasian Chapter of Palliative Medicine
AMA	Australian Medical Association
CPD	Continuous Professional Development
FRACP	Fellowship of the Royal Australasian College of Physicians
GP	General Medical Practitioner
HWA	Health Workforce Australia
MDT	Multidisciplinary Team
RACP	Royal Australasian College of Physicians
RACGP	Royal Australian College of General Practitioners
RDAA	Rural Doctors Association of Australia
RPCMPF	Rural Palliative Care Medical Purchasing Fund
Victorian DoHHS	Victorian Department of Health and Human Services
VRRPPC	Victorian Regional Rural Project in Palliative Care
VPMTP	Victorian Palliative Medicine Training Program

Section 1: Project Background

Creating a sustainable regional and rural medical workforce to ensure equity of access to quality health care for people living in these areas is a fundamental concern of rural policy in Australia. Health Workforce Australia (HWA, 2012) has found that although the number of medical specialists is increasing in Australia, there remains a geographical misdistribution primarily in regional and rural areas. This has been supported by the Medicine in Australia: Balancing Employment and Life (MABEL, 2014) studies into rural workforce issues that consistently identified workforce shortages and a worsening misdistribution in rural areas. Importantly, their research has identified the need to not only increase supply but also address the recruitment and retention issues that underpin workforce sustainability to solve this problem.

The projected increase in the age of persons living regionally and rurally and the prevalence of chronic and complex medical conditions particularly in the aged population highlights the need to have an expert medical workforce to effectively address and manage these concerns. The needs of this aging cohort, as well as those in the general population with a life threatening illness (malignant or non-malignant) ensure that an integral part of any regional and rural workforce strategy is to include and support medical practitioners and specialists with an expertise in Palliative Medicine.

Recently, the Victorian Department of Health and Human Services (DoHHS) palliative care workforce study (2013) identified that although the absolute number of Palliative Medicine specialists working in Victoria has increased significantly over the past 5 years the vast majority are located in metropolitan Melbourne and Geelong. More importantly, the study highlighted the shortfall in provision of palliative care services as well as Palliative Medicine specialists in regional and rural areas. Since 2008, Victoria DoHHS has committed to strengthen specialist palliative care services throughout Victoria, through the creation of the Victorian Palliative Medicine Training Program (VPMTP) which coordinates the state-wide training of both specialists and non-specialists in palliative medicine. To address the imbalance of service provision in regional Victoria the VPMTP has recommended a Victorian Regional/Rural Project in Palliative Care (VRRPPC) be undertaken to identify the professional and social supports needed to attract and retain Palliative Medicine specialists regionally and to explore new models of supervision and training for palliative medicine trainees in these areas.

Aim

To increase the workforce capacity of Palliative Medicine specialists in regional/rural areas of Victoria

Objectives

Primary

1. To identify and describe the professional and social supports needed to successfully attract and retain Palliative Medicine specialists to live and work in regional areas.

Secondary

2. To explore new models of supervision and training in regional centres to encourage the building of a regional workforce.

Section 2: Literature Review

The literature review included a focused rather than a systematic review of Australian and overseas studies (primarily U.S.A, Canada & UK) to identify and appraise the research evidence into rural health workforce recruitment and retention issues in relation to doctors and in particular medicine specialists. Key search terms included 'rural', 'recruitment', 'retention' and 'medical practitioners' including 'specialist' to further refine search. Whilst there is some evidence of research conducted into recruitment and retention issues affecting rural medical specialists it is apparent that the greater depth and abundance of research has focused on primary/general practitioners in rural regions. Importantly, the literature review provided evidence of 'what works' in relation to health workforce recruitment and retention and highlighted the need to employ independent approaches to address both issues when planning and refining strategies for building and sustaining health workforce capacity in these regions. The literature review informed the project and its direction by providing an evidence-based insight into the professional and social supports required to attract and retain specialists to live and work in regional areas.

2.1 Recruitment and Retention

"A health worker will accept a job if the benefits of doing so outweigh the opportunity cost" (Dolea, 2009).

Recruitment 'involves the attraction and selection of staff to a particular organisation or role and is a pre-requisite for retention'. Targeted recruitment strategies and selection criteria have been found to be important for retention as the better matched the individual is to the role the longer they are likely to remain in that role. Retention on the other hand, refers to the time between engagement and departure from the service and is a measure of length of stay. Retention importantly requires ongoing monitoring and evaluation of strategies used to ensure health professional and community needs are met (Humphreys, Wakerman, Pashen, & Buykx, 2009b, p.7-8).

2.2 What works?

Globally research has shown moderate to strong evidence for interventions targeting rural background, recruiting from and training in rural areas as strategies most likely to increase workforce capacity in rural regions. In addition, adapting curricula to include rural health issues has been found to improve competence and create more interest to work in a rural area. (Kondalsamy-Chennakesavan et al. 2015; Hudson & May, 2015; Hogenbirk, Miang & Pong, 2012; Roberts et al., 2012; Walker, DeWitt, Pallant, & Cunningham, 2011; Dolea, Stormont, & Braichet, 2010; Chauban, Jong,& Buske,2010; Sutton, Mayberry, & Moore, 2010; Humphreys et al., 2009b; Henry, Edwards, & Crotty, 2009). Rourke (2008) state involving skilled rural physicians in medical education is vital. Increasing the number of physicians interested in rural practice through role modelling positively influences attitudes to rural practice. Myhre & Holman (2012) found specialty-based rural programmes are critical to expose registrars to rural practice to shift attitudes to practising in rural regions. Their survey of 29 registrars found 45% said they were likely to practice rurally prior to experience and 76% following rural rotation. Similarly, a study of specialist training in Northern Ontario found specialists who trained in the region were more likely to practice there and also identified a strong association with duration of training in this region with a longer duration resulting in a greater likelihood of practising in the northern region (Hogenbirk et al., 2012).

Other education and regulatory interventions have included rural bonded scholarships and compulsory service, loan repayment schemes, conditional licensing and recognising overseas qualifications (Dolea, 2009). Arvier, Walker & McDonagh (2007) draw attention to the fact as 'most specialist medical training takes places in tertiary hospitals that can provide sophisticated support services as well as the 'critical mass' of population to sustain professional interest, it is a concern whether rural areas can match the high standard of training required for specialist practice' (p.7).

The authors found limited training opportunities, unsupportive workplace environment and inadequate professional development opportunities may be affecting internship choice and highlight the need to expand curricula to provide a strong focus on education and training opportunities in rural areas and provide alternative pathways to specialist qualification. The Rural Doctors Association of Australia (RDAA) regional rural and remote specialists survey also highlighted the need to have a national coordinated approach to training that will meet the needs of people living in rural communities and provide a pipeline of doctors with the qualifications, skills and experience for rural practice. Noted were the barriers or difficulties of providing training such as financial constraints, workplace and accreditation issues and also insufficient workplace infrastructure to support training (RDAA, 2012). The complexities of post graduate medical education with multiple organisations (i.e. specialist Colleges, Universities, Health Departments) all playing various roles in teaching, accreditation and funding have placed restrictions on rural training pathways and would benefit from greater coordination for health service delivery (Arvier et al., 2007).

In addition to education interventions there have been a variety of strategies used to attract doctors to rural regions including financial incentives such as rural allowances, loans (housing, vehicles), grants for family education and local environment management and support strategies such as improvements in local infrastructure, supportive supervision, flexible work contracts and reducing professional isolation through telemedicine/telehealth, professional networking and continuing professional development (CPD) opportunities (Buykx, Humphreys, Wakerman, & Pashen, 2010; Frehywot, Mullan, Payne, & Ross, 2010; Dolea, 2009; Grobler et al., 2009). A large number of independent studies into each of these strategies have shown different degrees of success. Wilson et al. (2009) comprehensive and critical review of interventions to address health workforce maldistribution to rural areas found the available evidence revealed strong verification for rural upbringing, career intent for rural medicine and post-vocational fellowships (although results are biased by self-selection) and moderate evidence to support interventions that focused on financial incentives (bursaries, compensation), clinical rotations and international recruitment. Weak evidence was noted for coercion (community service), CPD and supportive measures (family and lifestyle, back-up) to enhance retention. Incentives and coercion were also noted to address short-term recruitment needs and there is little evidence that supports their long term impact.

Furthermore the Cochrane review to assess the effectiveness of interventions aimed at increasing the proportion of health professionals working in rural areas found that whilst a variety of strategies including educational, financial, management and supportive strategies have been used there are no well-designed studies to say whether any of these strategies are effective or not (Grobler et al., 2009). Similarly, Buyx et al. (2010) and Dolea, Stormant & Braichet's (2010) review of retention incentives in rural areas found little evidence to demonstrate that any specific strategy is effective because of the lack of rigorous evaluation conducted with a possible exception being health worker obligation. Dolea at al. (2010) believe that a situational analysis including a survey of factors that influence choice of rural location is mandatory as a basis for selecting the most appropriate intervention. It is also important to emphasize sustainability for financial strategies such as scholarships, grants or higher salaries for people working in underserved areas for example, are dependent on funds available and are an important consideration in successful long term recruitment or retention strategies (Grobler et al., 2009).

Wilson's et al. (2009) review of rural recruitment and retention interventions particularly highlights the need for more evidence to evaluate CPD and support strategies as the little available evidence for the importance of time-off or back-up for rural practice indicates a dire need for research into 'retention strategies that focus on the integration of personal and professional support for rural doctors' (Wilson et al. 2009, p.8). A number of studies subsequent to this review have shown strong support linking CPD and professional satisfaction (Hatcher, Onah, Kornik, Peacocke, & Reid, 2014; Bourke, Waite & Wright, 2014; Toguri, Jong, & Roger, 2012; Campbell, McAllister, L. & Eley, 2012;

Curren, Rourke, & Snow, 2010; Chauban, Jong, & Buske, 2010). Rural CPD workshops, telephone, videoconferencing, telehealth and internet availability are seen as effective retention strategies to reduce geographic barriers, travel time and absence associated with distant onsite CPD (Curren et al., 2010). Toguri et al. (2012) survey of specialists in rural Canada found overwhelming support for CPD and additional training as being important for professional satisfaction. Chauban et al. (2010) survey of 642 rural practitioners has also found migration from rural regions could be effectively discouraged with the provision of professional relief (local tenens) and technology for professional back-up and formalising linkages with colleagues in referral centres.

Whilst evident from the literature review that many attempts have been made to address recruitment and retention strategies that may be amenable to changes, Humphreys et al. (2009) also emphasize that there are 'unmodifiable' factors that affect health professionals and their families' choice of rural location and decisions to stay. Strong empirical evidence exists between population size, geographical location and retention (Russell, Humphreys, McGrail, Cameron, & Williams, 2013; Humphreys, McGrail, Joyce, Scott, & Kalb, 2012). Specialization for example, is less viable where the population density is less and medical facilities are small. Regular visits by specialists working in collaboration with local generalists can be a more viable model of care to allow more seamless management of more complex cases (Carson, 2009). Proximity to capital cities is also important and excessive travel times and distances involved in rural practice can be viewed negatively. Toguri et al. (2012) states in Canada only 2.1% of all specialists from a 2007 National Survey were found to practice rurally as the size of the community and distance to the nearest referral centre impact on choice of practice location.

Communities too have different characteristics and vary in their ability to meet the social demands that a health professional and family may have in relation to recreation, education and spousal employment (Humphreys et al., 2009). Community /local resources and opportunities can either attract or repel health professionals from a rural region (Rourke, 2008; Humphreys et al., 2009a &b). Toguri et al. (2012) found 75% of respondents cited family reasons, safety and outdoor lifestyle followed by autonomy and case variety (60%) as the main reasons for choosing rural practice. Only 16% stated finances were a factor in their choice of a rural location. Similarly, Campbell et al. (2012) found rural lifestyle and diverse caseload as positive extrinsic factors and autonomy and community connectedness as important intrinsic factors. A community culture that is welcoming and supportive of healthcare professionals where community groups and healthcare professionals work together are related to perceptions of being respected and being able to achieve future goals, enhancing retention (MacDowell, Glasser, Fitts, Nielsen, & Hunsaker, 2010). Correspondingly, genuine community participation and ownership of the process is important in retention of health care staff and requires wide consultation and careful matching of health professionals to rural communities (Veitch, Harte, Hays, Pashen, & Clark, 1999). Jones et al. (2013) highlight the importance of personality as an important factor to explain why some individuals may be better suited to rural practice than others and found the probability of rural preference greater in those who demonstrated higher score on openness to experience, agreeableness and self-confidence. Sutton et al. (2011) similarly draw attention to the importance of a person's interpersonal skills, attitude and 'fit' with where the organisation in a particular community is heading, for successful recruitment and retention purposes.

It is clearly apparent that multiple factors influence attraction to and length of employment of healthcare practitioners to rural regions indicating that a flexible, multi-faceted response to workforce retention is required (Buyx et al., 2010). Professional and community support to rural workers to encourage rural practice, supportive supervision, internet access, community involvement projects, professional networks, a critical mass of doctors within a region to ensure practice viability, strong training experiences, access to community and professional resources, CPD opportunities to maintain and update skills and consideration to the needs of the family (i.e. access

to employment, health, education and social amenities) are examples of the many extrinsic elements that lead to professional and personal satisfaction (AMA, 2012, Dolea, 2009; Humphreys et al., 2009).

Hence, the best available evidence indicates that bundles of incentives that include financial (remuneration, salary packaging benefits); professional/organisational (CPD, career pathways, role clarity, infrastructure, leadership & management); and social (accommodation, educational and family related issues) are more likely to be effective (Cameron & Worthington, 2012; Humphreys et al., 2009a & b; Lehmann, Dieleman, & Martineau, 2008). As causes for retention are embedded in both personal and work-related factors, strategies must address these multiple causes simultaneously. Thus to be effective a comprehensive workforce retention strategy that bundles incentives is required (Humphreys et al., 2009b).

Humphreys and colleagues' increasing body of research emphasizes the strong relationship between job satisfaction and retention and outline a range of elements that need to be in place for workplace satisfaction and stress that any "dissonance between employee needs and workplace may reduce the level of worker satisfaction and trigger employee relocation to another job or place" (Humphreys et al., 2009b, p.9). Cameron and Worthington (2012) have similarly identified three domains of retention that include the professional, personal and community domains and state without fulfilment in all domains retention may be at risk.

From their research into rural and remote workforce recruitment and retention Humphreys and colleagues recommend the following core components of a 'rural retention workforce framework':

1. Maintain adequate & stable staffing- need to understand intentions & motivations of rural workforce, recruit the right person, adequate relief, mandated service/visa waiver

2. Provide appropriate & adequate infrastructure- IT& technical support, vehicle, housing

3. Maintain realistic & competitive remuneration- packaging benefits, retention bonuses

4. Foster sustainable & effective workplace organisation- employee induction & orientation programs, strong organisational leadership (vision), management & supervision, good collaborative organisational communication.

5. Shape the professional environment that rewards & recognizes individuals making a significant difference to patient care- preceptor/mentorship program, collegial support & supervision, CPD & conference opportunities, engaging in research and scholarships for academic pursuits, autonomy, leadership & management role, opportunity for promotion/career pathway within the organisation and role recognition (i.e. employees want to be valued for their contribution).

6. Ensuring social, family and community support –fulfil needs of all household members (childcare and family support).

(Buykx et al., 2010, Humphreys et al., 2009a & b)

This framework provides a foundation from which a more comprehensive and multi-faceted approach to workforce recruitment and retention can be planned and put into place to enhance Palliative Medicine specialists relocation to rural/regional Victoria. Recruitment, retention and satisfaction are increasingly recognised to be influenced at a number of levels: at macro-level the health system, health facility/workplace at micro level and health worker characteristics at the individual level. Each level is also influenced by the overall context (political, socio-economic &

cultural environment). Interventions thus need to be targeted at each level simultaneously (Humphreys et al., 2009a&b; Humphreys et al. 2007).

2.3 Document Review: The Local Context: Victoria

Document review has incorporated both Victorian and Federal Government planning documents for rural and regional health and also policy and strategic directions for delivery of palliative care services in Victoria. Relevant Australian Medical Association (AMA), Rural Doctors Association of Australia (RDAA) and Victorian Regional Palliative Care Consortia reports are also included in the review as they link closely with government policy directions (Appendix A). The important information that these documents provide for consideration in view of their impact in shaping long term project outcomes include the well-recognised challenges inherent in recruitment and retention of specialist doctors in rural regions and the policies developed to address these challenges (Table 1). Consistent with the literature review targeting students with a rural background, adapting curricula to include rural health issues, the establishment of rural training schools and various financial incentives are examples of strategies used over many years to address workforce shortage in regional and rural areas.

The Victorian Department of Health and Human Services (DoHHS) strategic directions for all people with a life-threatening illness and their families and carers is to ensure access to appropriate services wherever they live in Victoria, seamless, quality care that is informed by evidence and research and support from their communities (Victorian DoHHS, 2011 a &b). To this end strategies to enhance recruitment and retention of a specialist palliative medicine workforce in rural /regional Victoria is an ongoing priority to ensure equity of access to palliative care.

Table 1: Rural Medical Workforce Shortages and Key Government Initiatives

Workforce shortage-the issues in Victorian rural regions	Recommendations from AMA & RDAA to attract specialists	Victorian Government initiatives/policies
• Inadequate remuneration • Work intensity/long hours • Lifestyle • Filling multiples roles • Professional isolation • Poor employment or education opportunities for family members • Continued withdrawal of services from regional/rural areas. i.e. hospital closures and downgrading of other services • Lack of critical mass of similar doctors • Limited educational opportunities • Inefficient public hospital administration	• Financial incentives including rural loading • Flexible work practices & access to locum cover • Sensible, safe & family friendly on-call commitments • Comprehensive support from a broad range of local specialists/GPs/hospital medical staff/MDT • Family support-opportunities for spouse employment & optimal education for children • Affiliation with Rural Clinical Schools & University Department of Rural Health	• Encourage retention of home grown graduates in rural regions- rural scholarships/HECS reimbursement schemes • Medical trainee rotations to rural areas(undergraduate & postgraduate) • Building regionally based post graduate training pathways • Rural clinical schools-strengthening links between university and health sector • Collaborative health service planning and policy development to build a health workforce that meets the needs of the local community/MDT support

Workforce shortage-the issues in Victorian rural regions (cont)	Recommendations from AMA & RDAA to attract specialists (cont)	Victorian Government initiatives/policies (cont)
• Extensive travel time in provision of work service	• Enhance formal links between regional/rural centres (the hub) & metropolitan hospitals (spoke) for specialised services • CPD opportunities • Supervision and education role acknowledged and rewarded • Adequate infrastructure support	• Palliative Care Consortia for regional planning & capacity building • Recurrent funding from RPCMPF* to improve specialist palliative care services in rural Victoria • Support for local CPD access • Upgrades at various regional hospitals, new hospital developments • Establishment of Rural Relocation Fund • Improved/planned access to information technology e-Health, telehealth & remote monitoring & high speed broadband

(AMA, 2012; Health Workforce Australia 2012 &2013; RDAA, 2009; Victorian Department of Health and Human Services 2011 a &b)

**RPCMPF: Rural Palliative Care Medical Purchasing Fund*

2.3 Current Picture- Palliative Medicine Specialists in Victoria

The Australasian Chapter of Palliative Medicine (AChPM) currently advises there is an existing shortage of Palliative Medicine specialists in Australia and highlight various changes in service delivery that may increase the demand for a palliative medicine workforce including telehealth by being able to improve the remote advice given and support tor rural health professionals; and changes in referral patterns to include more patients with non-malignant diagnoses such as renal failure and neurodegenerative diseases alongside the ageing of the Australian population (Health Workforce Australia, 2012).

The provision of Victorian Palliative Medicine Training Program (VPMTP) (Appendix B) has been a key initiative supported by the Victorian DoHHS to address the supply of Palliative Medicine specialists and a small but steady throughput of training has occurred since 2008 with a total of 24 trainees awarded specialist qualification since inception. 48 diplomas in palliative medicine have also been conferred to date in Victoria which will over time build the palliative medicine non-specialist workforce. Importantly, as a consequence there are resident Palliative Medicine specialists working in larger regional centres such as Geelong, Ballarat and Bendigo. There are however no resident Palliative Medicine specialists in the Hume or Gippsland regions which currently rely on visiting specialist services (Table 2).

Other key government strategies developed to improve and build palliative care service capacity in rural Victoria include for example, the Rural Palliative Care Medical Purchasing Fund (RPCMPF) established in 2006-07 that provides rural regions with funding for additional specialist medical palliative care to address gaps in service. It also assists in building capacity for rural regions to

become self-sufficient in providing specialist medical palliative care. In some regions the RPCMPF has been used to employ new Palliative Medicine specialists or extend the hours of specialists already employed within the region. In other regions partnerships with metropolitan or other rural services have been established to purchase specialist palliative medicine services from outside the region (Victorian, DoHHS, 2009). Furthermore, enhancement of regional planning in palliative care has been particularly strengthened with the development of Palliative Care Consortia in each region of Victoria (Appendix C) to ensure government policy reflects local community need. The consortia bring together all funded palliative care services to undertake regional planning, coordinate service provision, build capacity and identify priorities for future service development and funding (Victorian DoHHS,2011b).

Table 2: Regional Victoria-Palliative Medicine Specialists

Regions	Population	Palliative Medicine Specialist Service
Barwon South Western (BSW)	378, 724 (2011)	Barwon Health Palliative Care Consultancy Service - well-staffed with Palliative Medicine specialists (3+). Palliative care support to SW and Colac regions
Grampians	220,878 (2013)	Grampians Palliative Care Service/ 2 Palliative Medicine specialists in region Impacts: Ballarat Regional Integrated Cancer Centre, Stawell Health & Community Centre (2013)
Lodden Mallee	308,000(2013)	Loddon Mallee Regional Palliative Care Consultancy Service/ 1+ Palliative Medicine specialist in region. Visiting/consultative specialist palliative medicine services to Mildura from Peter MacCallum Cancer Centre Impacts: Bendigo hospital project & regional cancer centre (2016)
Hume	267,071 (2011)	No regional Palliative Medicine specialists-recruitment aims. 2 community nurse-led regional consultancy services to transition & develop with Goulburn Valley Health, Shepparton & Albury Wodonga Health. Visiting/consultative service (based at Shepparton & Wangaratta) & telephone support to Hume region from the palliative medicine consultancy service at St. Vincent's Health, Melbourne. After hours nursing triage service also provided by Caritas Christi. Impacts: Albury Wodonga Regional Cancer Centre (2016)
Gippsland	269,791(2013)	No regional Palliative Medicine specialists-recruitment aims. Visiting/consultative specialist palliative medicine services from Calvary Health Care Bethlehem, Monash & Peninsula Health

(Victorian DoHHS, 2011 a &b; Victorian, DoHHS, 2009; www.health.vic.gov.au/regions)

Attention to infrastructure with the development of specialist medical facilities in rural and regional centres has also contributed to the socio-economic sustainability of these areas by enhancing employment opportunities and reducing the need for medical evacuation to urban centres (RDAA, 2009). Adding strategies to address specialist workforce shortage that include active support for families moving from metro centres, sensible-safe on-call commitments, CPD grants, income comparable to metro practice, up-skilling GPs (to provide back-up specialist service) and the formalisation of links between major academic centres and rural areas (with the option to transfer between the two) will build specialist workforce capacity in rural regions (RDAA, 2009). Recommendations from the RPCMPF evaluation similarly identify and recommend up-skilling of general practitioners as an adjunct to providing good access to Palliative Medicine specialists in rural regions (Victorian, DoHHS, 2009).

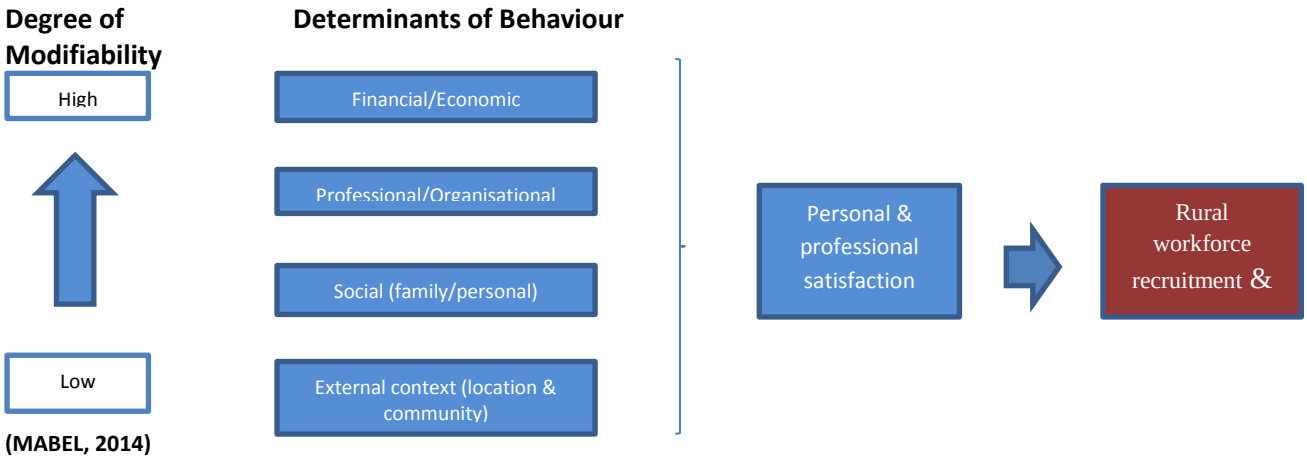
A continued commitment to training medical practitioners in palliative medicine is an important strategy to address shortage in supply of both Palliative Medicine specialists and GPs skilled in palliative medicine for palliative care service equity in rural/regional Victoria. Clearly, this is one strategy alongside attention to the multifaceted factors that affect both personal and professional satisfaction in living and working in rural areas. Continued monitoring and evaluation of strategies employed to attract and retain Palliative Medicine specialists in rural and regional Victoria is crucial to enhance workforce capacity and for long term sustainability of specialist palliative care services.

Section 3: Research Design & Methods

3.1 Research Framework & Scope

Humphreys and colleagues under the auspice of The Medicine in Australia: Balancing Employment and Life (MABEL) centre for research excellence in medical workforce dynamics have developed a conceptual frame work (2014) outlining the key determinants of behaviour that impact on the stability and integrity of the rural workforce (Figure 1). The four key elements of this framework have been used as the central thematic areas of research to address the Victorian regional/rural palliative care project objectives. The project is limited to an exploration of the professional and social supports needed to enhance recruitment and retention of Palliative Medicine specialists in rural regions in Victoria and as a result identify suitable models of supervision, teaching and support in regional/rural areas to build workforce capacity. Whilst it is recognised both macro and micro environmental issues for example, health policy and workplace leadership/management can impact on workforce recruitment and retention, this has not been the focus of the study. In addition, the project did not address the implementation or maintenance of Palliative Medicine specialist services in these areas.

Figure 1: Key Determinants of Behaviour



(MABEL, 2014)

A logic model underpinned the research design to provide a conceptual map of the project's operations by clarifying project inputs, activities, outputs and intended outcomes. The purpose of the logic model (Appendix D) is to describe the underlying causal assumptions linking project objectives and activities with project outcomes. It is a projects 'theory of action' about the causal linkages among various components of the project: its resources, activities, outputs, short-term impacts and long-term outcomes (Hawthorne, 2000, p.43).

3.2 Overview of VRRPPC Project Methodology

A qualitative data collection approach and subsequent analysis was used to meet key objectives and provide a comprehensive understanding of issues affecting rural practice. The project was conducted in three stages, involving 8 discrete steps (Figure 2).

Data was primarily collected from semi- structured interviews utilising a question guide developed using the MABEL framework and literature review (Appendix E). Interviews were conducted with stakeholders involved in delivery of palliative care across Victoria. Primary stakeholders included key regional specialist staff (i.e. Palliative Medicine specialists, Executive Health Service staff, Palliative Care Service and Consortium Managers) in the Barwon South Western, Grampians, Loddon Mallee, Hume and Gippsland regions and Palliative Medicine Advanced Trainees. The sample was purposive and snowballing techniques added depth to the sample frame. The sample size was felt by the

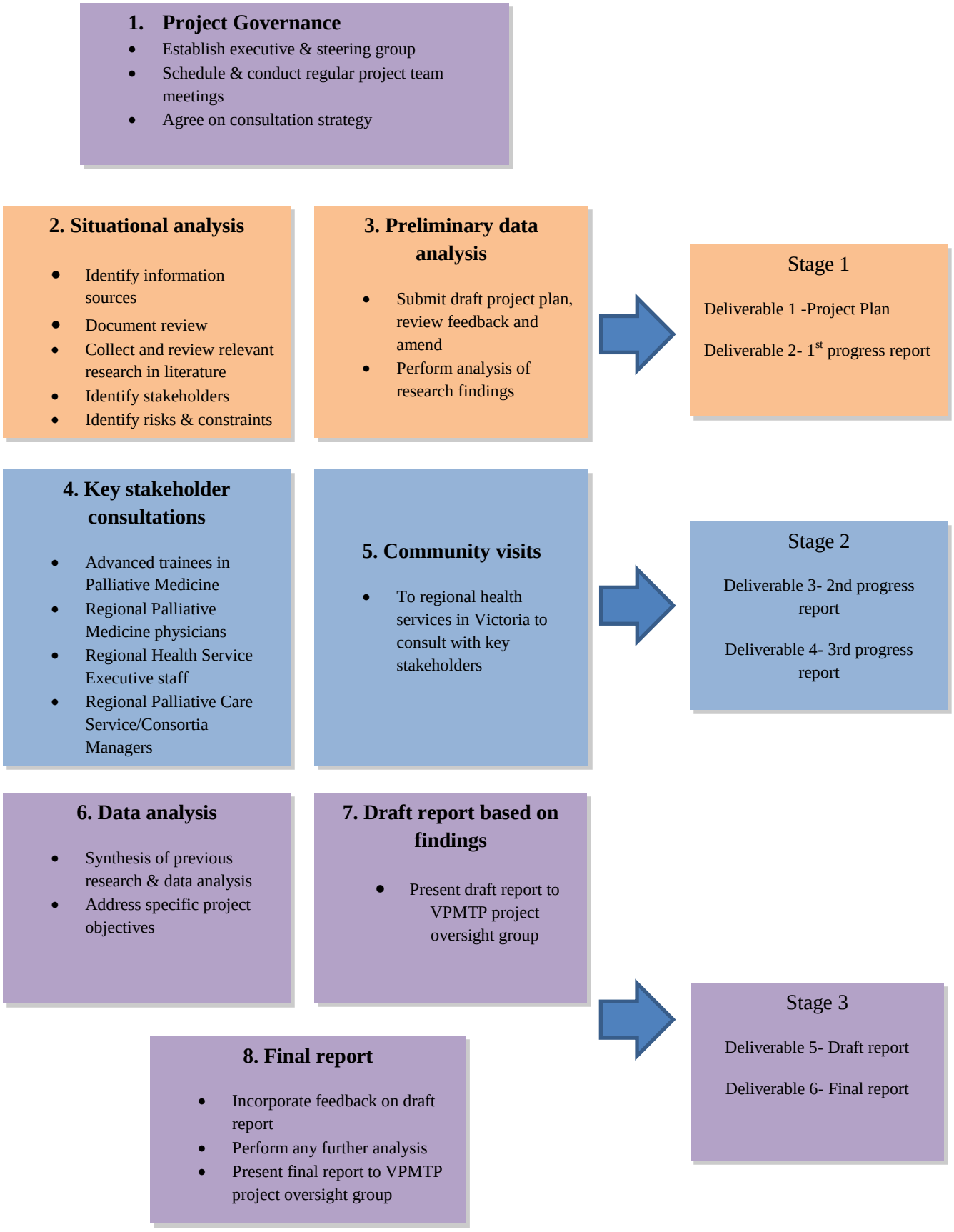
VPMTP oversight group to provide sufficient vigour to the study to achieve a full and sophisticated understanding of the professional and social supports needed to attract and retain Palliative Medicine specialists to live and work in regional areas.

Interviews conducted with palliative medicine trainees and regional palliative care physicians tapped into interviewee perceptions and experiences of rural clinical practice, and the challenges of living and working rurally. All interview transcripts were de-identified/coded and data was analysed to broadly identify key emerging themes within to analyse interviewee responses.

3.3 Ethics Approval

Following institutional St Vincent's hospital HREC-A ethics approval, participants were recruited by phone or email. All participants received a letter outlining details of the project and signed consent was sought. To protect anonymity and confidentiality all data were de-identified before analysis and reporting.

Figure 2: Overview of VRRPPC Project Methodology



3.4 Results

Twenty-seven individuals were interviewed. The sample consisted of a range of key specialist palliative care providers throughout rural/regional Victoria (Table 3). The Australian Standard Geographic Classification (ASGC-RA) is used to categorise these areas and is broadly based on the physical distance of a location to the nearest urban centre based on population size (Australian Government DoHHS, 2013). Although interviews covered wide ranging issues involved in recruitment and retention of specialist medical staff in rural regional Victoria, consistent themes clearly emerged from the post-interview analysis and coding process.

Table 3: Demographics- Palliative Care Health Service Personnel (N=27)

Victoria-Site	Resident Palliative Medicine Specialists	Visiting Specialist role	GP with diploma	Advanced Trainee	Health Service Director	Palliative Care Service Managers	Total
Large regional centre (RA1)	2			1			**3**
Inner regional centre (RA2)	5	2	1	2	5	7	**22**
Outer regional centre (RA3)		1			1		**2**
Total	**7**	**3**	**1**	**3**	**6**	**7**	**27**

NB: The average age of physicians was 45years and 5.3 years in a specialist palliative medicine role.

The thematic analysis revealed a range of factors that influenced professional and personal fulfilment in regional and rural practice. Five overarching themes broadly explained the data (Figure 3) each containing a series of experiences and conditions that facilitated and sustained rural specialist practice. Further, Table 4 provides a snapshot of enabling strategies associated with each theme to enhance professional and personal satisfaction in regional/rural Victoria.

Enablers of Regional/Rural Practice

The Fundamentals of Professional Specialist Practice

A Critical Mass

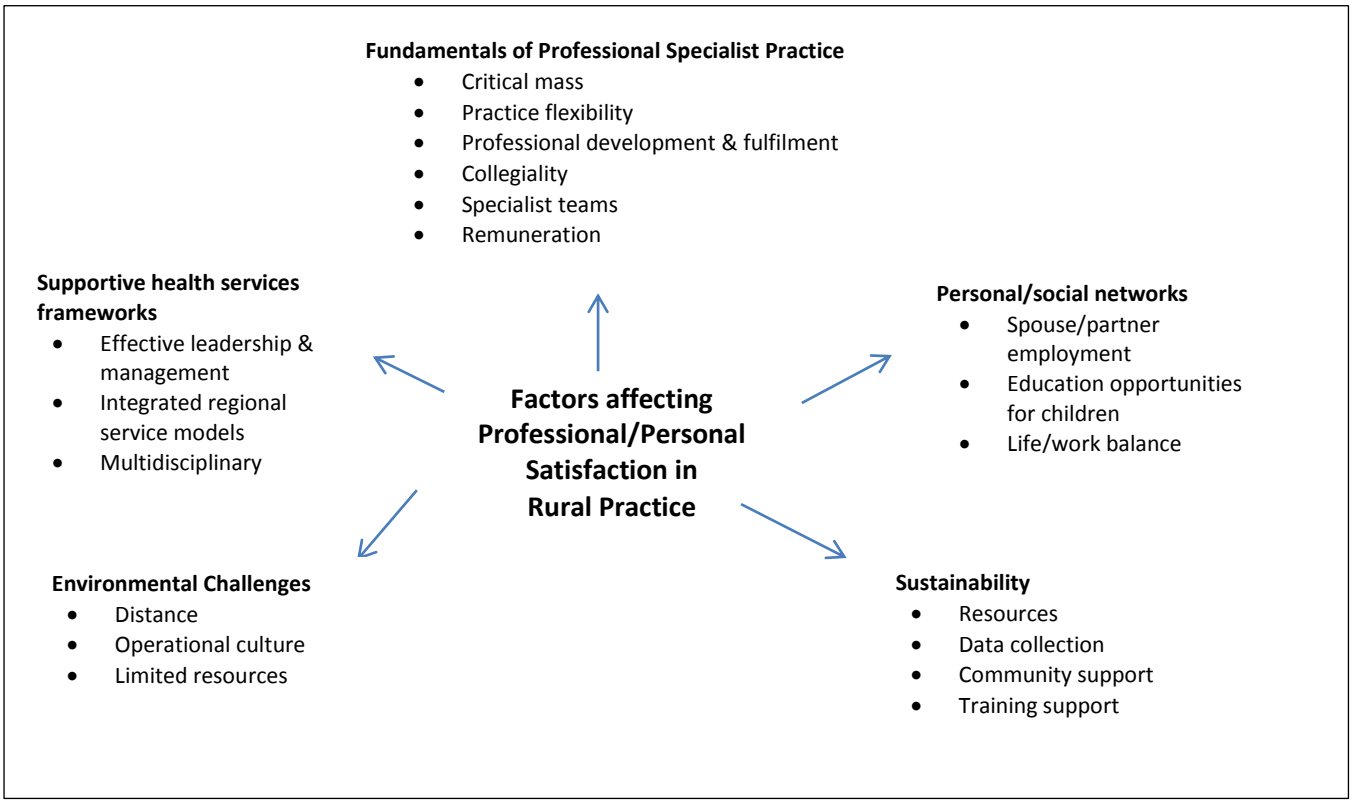
The most distinct and recurring theme in interviews conducted is the need for peer support. There was a prevailing sense amongst palliative medicine specialists that professional isolation and excessive workload were key determinants of 'burnout' in rural practice. Several mentioned the difficulties associated with working in a solo practice, the nature of the work (caring for the terminally ill) and the pervading sense that you always need to be available. As the following Palliative Medicine specialists (PMS) stated:

…to live and work as an isolated palliative care doctor… because when things are difficult in palliative medicine they can be very difficult, you know, watching someone die in pain and not being able to do anything about it, handling a family that's angry … day after day in the wars by yourself is not fun…you really need methods of support

And

I mean the potential for a lonely existence is always there, the potential for overwork is a major concern, and certainly talking to other palliative care doctors who are in the country… or advising anyone who went there, I'd say you really need to be very careful about your overall workload, make sure that you get plenty of time off, and that you can get away, and keep some balance in your life. The professional isolation is an issue.

Figure 3: Themes for Professional and Personal Satisfaction in Regional/Rural Practice



In fact, a critical mass is overwhelming mentioned as the most significant aspect of rural palliative medicine practice and is seen to be crucial for sustainability of the role. The 'knowing' and understanding of the particular challenges in a rural practice and the consequential support derived from having another palliative medicine specialist there on the ground, working within the same environment, to discuss effective strategies to deal with difficult complex cases is important to withstand the stressors involved when caring for dying patients and their families. The ability to debrief and seek advice from another palliative medicine specialist with knowledge of the patients and the specific rural health system was emphasized as an important enduring factor of practice.

…that's the reason why peer support is so necessary to be able to have a common understanding of the way that we work in palliative care and to support each other with the distress that comes from dealing with people who are dying all the time (PMS).

And

It is really useful having someone there by phone or video-link but it's not the same as having someone there on the ground (Advanced trainee).

Working in a small community where you may be caring for people that you live and work with was also highlighted as one of the unique and stressful challenges of rural Victoria. The need for peer

support in this context was also a consideration in decisions made whether to practice rurally in more remote and isolated conditions. As one advanced trainee emphasized:

In the country you don't have a choice, there is no other service so you will be looking after colleagues and families that can be especially professionally quite challenging when you couple that with resource limitations, professional isolation so there is more challenges- so having adequate support for that would very important, more important than in Melbourne.

Furthermore, lack of available peer support was seen by advanced trainees in the discipline as a significant deterrent for rural practice. For a junior consultant the need for peer supervision and support is essential for their ability to gain confidence in their practice. Working in a team of specialists with high-level skills and experience was in their view a pre-requisite to transitioning to more independent practice.

The other thing is being isolated if you are the only specialist there even if you have support from other clinicians it's not the same as working in a big team of 6-7 pall care specialists some of whom would be quite senior and always turn to in person readily for support (Advanced trainee).

The need to have a critical mass of specialists was a congruent theme across all service personnel and a well-recognised issue in attracting, supporting and sustaining rural practitioners. The practical and personal support, the sharing of ideas for best practice, discussing especially difficult cases with other palliative care specialists who worked and lived in the area were vital elements to sustain physicians in their role. Regional health service employers also recognised the incompatibility with retention of a solo specialist being 'continually available' as this is clearly in their view not sustainable. Creating an environment where there is peer support to reduce professional isolation, backfill support for annual leave/illness and professional development activities are drivers of workforce recruitment and retention. As one Health Service Director stated:

…if you share the load between three and they're not all full-time even though it's slightly more expensive, it's much more flexible.

Table 4: Enabling Strategies to enhance Professional and Personal Satisfaction in Regional/Rural Specialist Palliative Medicine Practice

Factors affecting Professional/Personal satisfaction in regional/rural practice	**Enabling Strategies**
Fundamentals of professional specialist practice • Critical mass • Practice flexibility • Professional development & fulfilment • Collegiality • Specialist teams • Remuneration	• Minimum of 2 physicians to enable sharing of practice responsibilities including on-call, leave etc. • Education/research roles to supplement employment • Maintain links with large metro tertiary centres for education, ongoing training & support • Build strong relationships with other specialist groups in region through specialist palliative care inpatient services • Education & training for healthcare staff • Incentives for outer regional areas
Factors affecting Professional/Personal satisfaction in regional/rural practice (cont….)	**Enabling Strategies (cont…)**

Supportive Health Service frameworks • Effective leadership & management • Integrated regional service models • Multidisciplinary(MDT)	• Regional model to meet community needs • Ideally services available linking community, hospital & hospice care. • Psychology/psychiatry and allied health support
Personal/social networks • Spouse/partner employment • Education opportunities for children • Life/work balance • Proximity of extended family & friends	• Secure employment opportunities • Quality of secondary education important • Normal work hours/including after hour commitment/backfill support/family time • Extended families within 2 hour radius of travel preferred
Environmental challenges • Distance • Operational culture • Limited resources	• Mechanisms to enhance patient home-based care (access to medications/equipment); promote telehealth use to maintaining professional connections • Increase education & role impacts in health services to overcome resistance /lack of awareness of specialist interventions • Staff skilled in palliative care/MDT support • Enhance rail services in some regional areas
Sustainability • Resources • Data collection • Community support/needs met • Training	• Support for specialist MDT service i.e. regional up-skilling/further education opportunities for healthcare staff & education/support for designated telehealth practice • Evidence based practice- important for ongoing funding • Community education- benefits/limitations of specialist role • Flexible learning and supervisory approaches for trainees

Practice Flexibility

Flexibility in practice was recognised by both employers and employees as beneficial to meet the health service needs of regional Victoria and an effective strategy to sustain palliative medicine specialists in practice. Education or research appointments that were adopted as a portion of their equivalent full-time (EFT) complement fostered pursuit of interests for professional development and flexible working hours to accommodate family needs also provided a work/life balance. The affiliation of regional health services with local universities to facilitate teaching roles in undergraduate and post graduate medicine was widely recognised as important to attract physicians to regional areas.

My goals can be met here particularly so because I have that dual role as a consultant and role at Melbourne & Deakin Uni where I can pursue that teaching side as well as my palliative care side. (PMS)

Health service employers especially in smaller regional centres also identified the need to have physicians flexible in their practice to work in areas such as general medicine in addition to palliative care, to meet health needs of the community. Effective and efficient use of resources to provide equity in care is essential for health service sustainability and is an important consideration emphasized in recruitment to regional/rural health services. The characteristics needed for rural practice to meet regional health service needs as one employer highlighted:

One, initiative; two, self-motivation; three, flexibility; … an ability to work across the service, not just within palliative care…Now, in bigger places, of course, you'd be more wanting someone who's dedicated to the process and probably is a singular specialist… But in smaller places… you have to sometimes compromise and also have to be a bit more flexible and agile in terms of being able to respond to changes or need.

Meeting the needs of the community, acknowledging the context in which care is delivered and balancing other service requirements are important considerations for regional/rural health service workforce planning and management.

Professional Development and Fulfilment

Variety and scope of practice, autonomy, continuity of care, delivery of health care staff education and service development opportunities were universally seen as the benefits of rural palliative medicine practice. The ability to use and develop a wide variety of skills, empower regional health staff, work across a variety of settings (community, inpatient hospital & hospice) to provide seamless care, to be responsive to unpredictable patient circumstances and changing needs (reach across practice settings) is a key attraction to working in regional/rural settings.

…the other thing that really influenced me was that I believe that the balance, the work that I do here, those three particular arms of work, you know, community, in-patient, consult are not always easy to get in large city areas… And, of course, the other corollary to that is to have an important education or supportive role in the region so that you're not just doing clinical work, you're actually spreading the word, if you like, and spreading the knowledge and the skills and the confidence to continue caring for these patients (PMS).

Role recognition and respect and health service staff 'seeing' the benefits of palliative medicine to patient care was clearly important for professional credibility and satisfaction. The relief or reduction of distressing symptoms was clearly a demonstration of the value of the role. For Palliative Medicine specialists a visible presence and influencing improved patient care outcomes affirmed their role to the wider community.

My presence in the community raised the profile a bit of palliative care. Even the GPs seemed to appreciate having a phone conversation about symptom management with myself (PMS).

And

…to actually try and influence people's practice you need to do that by making sure they do know you're available but you also have to demonstrate to them that you're actually quite helpful and not intrusive (PMS).

As one Palliative Care Service Manager stated:

The clients that have seen these palliative care physicians have nothing but praise for them, so it actually gives the client a lot of confidence in us that we're actually working with them to support them and give them improved symptom management and just enhance the service tenfold.

For regions with a visiting palliative medicine service although their presence did raise the profile of their role in the community, the limitations of drive-in drive-out visits and not being there 'often enough' to have a lasting impact on referral patterns was noted.

I think the problem is the time is so limited that people forget to refer patients to them. Also they don't have enough of a presence for things like providing enough clinical education, clinical pathways so our own staff can manage pall care patients better. There is still room for improvements in that general building up of quality of care (Health Service Director).

And

I think one of the big things when you don't actually have a medical person here is that you get used to sort of doing what you think will work and your experience, and I'm not belittling our experience here at all. But I guess what I'm saying is that you sometimes don't recognise what you don't recognise (Palliative Care Service Manager).

A specialist palliative medicine presence is acknowledged by many rural health service staff as important to enhance their knowledge of optimal palliative care symptom management and for many specialists this is a very satisfying aspect of their role when education is embraced. Whilst uptake of education offered by visiting specialists in some regions has been suboptimal other regions with established specialist services that provide regular education and clinical support are witnessing the benefits in terms of wider regional confidence and self-sufficiency in practice. As the following Palliative Care Service Manager highlighted:

…when we see them on a regular basis and we're up-skilling them and they're educated and, you know, even their district nurses are more educated…we can be responsive but I think the great thing is that these guys are really taking responsibility and they would much rather use their local GP than call us because it's about empowering their GPs in their region and, you know, it's sort of teaching the village to fish sort of stuff.

The following critical incident also highlights not only the professional satisfaction in empowering regional health service staff but illustrates the impact of specialist medicine support and presence in the more remote areas of rural Victoria. As one Palliative Medicine specialist states:

Recently we had a man dying from MND… quite complex case. The GP had not seen a patient like that before with MND and felt quite out of depth. By doing some initial good symptom management planning, going out for the initial assessment and to meet with them, to work with the family…and every week I say I will ring you Monday morning and see how things are going to touch base. So I was ringing them once a week for a consult and if there was anything more difficult I could support them in that.

And

I think if you put a lot of investment early in the care to set up the client and set up those relationships you can do more of the care remotely…we make sure everyone engaged in the care knows what is happening and they now contact us readily if needed…we do a lot of telemedicine.

In addition to the scope and variety involved in their clinical roles, continuing professional development (CPD) opportunities was viewed as fundamental to skill maintenance and development. The ability to network /facilitate clinical partnerships/links with large tertiary metropolitan centres, to engage in research and education with universities and the wider palliative medicine community was also seen as essential to ensure palliative medicine specialists in rural areas were not only kept abreast of new developments in their practice but also active contributors to improved evidence-based palliative medicine practice.

…trying to remove the concept of being isolated compared to the metro role. Having ties or links to a larger metro service or being able to participate still in journal clubs or education sessions at the larger metropolitan services would see routinely, things for your own ongoing professional development (PMS).

And

I think PD is not about just going to go to lectures etc. its being a part of a group of people going through the same journey to be pall care consultants, having people around you that you are seeing every so often to talk with and network with, have a chat with is really an important part of that (Advanced trainee).

Allocated time and backfill support to pursue professional development activities is viewed as important to sustain long term regional/rural practice and for Palliative Medicine specialists to feel engaged and connected to the wider specialist network. It is also seen to ensure best practice and equity of care for rural populations.

... some help with funding to be able to attend educational events with their broader peer community and with centres of academic excellence in other places, so coming down to Melbourne for the Centre for Palliative Care events or the ANZSPM conferences would be really important to support them to do that and to try to backfill them, you know, to give the relief so that their role is still happening when they're absent (Visiting specialist).

And

I think what is really important is having an arrangement with a metro based service because one of the issues a specialist has is the myth that they become deskilled in regional areas so they want to keep going back to metro to reskill or up-skill so having some sort of arrangement with a metro…(Palliative Care Service Manager).

The reduced feeling of professional isolation and the enhanced commitment to rural practice through maintaining wider professional connections is also recognised as important for retention of specialists by health service employers in regional Victoria and is supported in health service contractual agreements. Maintaining strong links and connections with metropolitan tertiary services is an important facet of professional development for rural specialists. This may involve the ability to be involved in metropolitan based practice at different intervals as part of their employment contract.

…the recognition of being a specialist you need some time to attend to ongoing education and training. Under the award the full time specialists should be undertaking x amount of clinical but certainly if they need to once a fortnight or once a month attend education in Melbourne that they can get away and do that. (Health Service Director).

Collegiality

Building and engaging in relationships with other specialists in the region is recognised as being important for collaboration/ professional development, mutual respect and early referral. It is also important for sustaining specialists in practice where they may be a minority and other specialists can provide like-minded interaction and professional support. Continuity of patient care and sharing insights and strategies where specialities collide is an important outcome of collaboration. As one General Practitioner (GP) working in a specialist role highlighted:

She is only in her late 20s. I have got to say my support there has been a local oncologist. He hasn't provided her with antineoplastic drugs for a very long time and he confided in me 6 or 12months ago

the reason he was still involved in her care was to be there for me which I very much appreciated because if I found that I was the only doctor involved in this young woman's care I would have found it extremely stressful.

A Palliative Medicine specialist further emphasized the professional benefits of cross speciality collaboration.

…there is rehab, geris, community and pall care all come together and we talk across topics, we look at common interests as well as those that are specific to the individual specialty and we then have meetings. We go upwards and downwards, that is, that there's opportunity also for specialists to interact within the division…

Health service frameworks that facilitate specialities working within a similar paradigm to come together under one division to share skills and resources have mutual benefits for strengthening the overall health service delivery of the organisation, for patient care outcomes (early referral) and for the specialists themselves. A consistent approach to patient care is as the following health services director states, beneficial for all involved.

…this service here has four disciplines under the one division, so you've got geriatrics, rehab, palliative care and community services. That combination means that palliative care is not floating on its own, unloved and unwatched… it's sort of part of a greater whole….Therefore, if you're trying to attract someone it's actually easier to attract someone into that – with that combination rather than just a pure pall care job (Health Service Director).

Such frameworks not only actively enhance collegiality between disciplines, but also affirm the need for a palliative care approach (the relief of distressing symptoms) to care for the increasing ageing population experiencing life-threatening malignant and non-malignant diseases. In fact, palliative care is increasingly being viewed as a natural continuing care approach for all persons experiencing a life-limiting illness/condition. As one Health Service Director highlights, there are many other patients that could benefit from specialist palliative intervention and in this sense it is important that collegiality between disciplines is fostered.

… the majority of the care needs being met with respect to palliative care is related to cancer and oncology type patients, as opposed to palliative care related to ageing and neuro-degenerative processes which tends to be the forgotten soul in all of this. So it's really that we haven't caught up in terms of our models of care and strategic forward plans in region.

Specialist Teams

Many palliative medicine physicians raised the issue of working within specialist teams as important to practice longevity. The support, being part of a 'group' with the same palliative care mindset and specialist abilities to care for terminally ill patients with the many complexities involved, to share the 'load', to review practice and explore strategies to enhance patient care were all factors that sustained them in practice. As the following Palliative Medicine specialists stated:

…the support I got from nursing staff is one of the things I like about palliative care, always liked working with nursing staff actively and being in groups and you know I still push the idea of teamwork…

And

Being part of a comprehensive palliative care service or team that has specialist nursing staff as well as other palliative care consultant staff, debriefing and professional development activities and to work on models of care and research…is satisfying…

There was also the recognition of the skill set and wealth of experience of the palliative care health regional/rural workforce largely comprising of nursing and GPs who had been delivering palliative care for many years, essential to support specialist practice. The level of GP knowledge of specialist palliative care practice in some regions was however quite variable.

…there are very experienced GPs as well as general physicians with specialist palliative qualifications that closely support the palliative care service and the nursing staff in each community service would be able to recommend GPs that had particular experience or skill set in managing palliative care patients and that's very helpful and useful (PMS).

The intricate knowledge of the patient available from other palliative care workforce personnel involved in the care trajectory and being able to tap into that experience was essential for new or visiting specialists coming to the region to be able to quickly assess and implement effective interventions. A specialist team also was seen to ensure a consistent approach to patient care.

…that you're actually part of a team… OK you've got to make some important decisions because you are the doctor and you've got the prescribing rights, but you've also got a lot of experienced people around you, you've got to listen to and take notice of because they are often with the patients a lot more than you are… I guess there's a degree of humility in that, you know, as a doctor to be really open to suggestions and ideas (PMS).

Remuneration

Although financial remuneration is important for the role, the award for palliative medicine specialists that includes time and support for professional development activities being securely in place sees this issue barely raised in their interviews. Advanced trainees were however cognizant of the importance of being financially rewarded for their specialist skills. Health Service Directors especially in outer regional areas recognise the need to have additional incentives in place to attract physicians to the area. There is also concern within the sector that funding required to support the specialist palliative medicine role from limited palliative care funding pools will result in a trade-off for other services.

1. Supportive Health Service Frameworks

Effective Leadership and Management

An important consideration in the successful recruitment and retention of palliative medicine specialists to regional/rural Victoria is the characteristics of the health service. A larger health service that is well managed with strategic plans in place, resourced, with medical director leadership supportive of the role is as expected, an attractive career proposition for Palliative Medicine specialists.

I think I was lucky when I arrived here, I had great support from the, you know, Executive Director of Medical Services right through… I just feel I'm encouraged to be involved in a range of activities within the hospital and outside the hospital that's relevant to our work (PMS).

And

Our Manager is very responsive, very open to things and seeing them through fruition…the Medical Director is very keen to make sure our role is professionally and personally sustainable…(PMS).

And as one advanced trainee further highlighted:

...the most satisfying thing is to see a health service running smoothly and patient's needs being met to their satisfaction...is the most satisfying thing in medical care. It all depends on how much funding and what the health service is willing to provide to have the right people.

Conversely, as the following comment illustrates working in an environment where specialist palliative care service delivery is ill defined is fraught with challenges and frustrations and potential sustainability problems. As one Palliative Medicine specialist explains:

…so there is no director of palliative medicine, palliative medicine comes under geriatrics and for a significant number of years there's been no medical leadership on that side. We now have a new director and he certainly has got quite you know, a good few ideas about how to expand and improve so that's pretty promising…

A greater palliative medicine physician presence in some regional/rural hospitals (the central hub) for health services was also seen as essential to provide a comprehensive palliative care service and for greater care continuity, control of outcomes and for discharge planning. Furthermore, it was viewed as important to enhance a greater awareness of specialist palliative medicine practice amongst health service personnel through opportunities for education and to enhance collegiality and early referral from other specialists.

I think ideally patients have different needs at different stages and often they do need inpatient care so being able to have admitting rights or control of palliative care patients in an inpatient setting would be important and not have complete loss of control if you are referring someone to hospital over their treatment or outcomes there (PMS).

Supportive governance is viewed as important for sustainability and is facilitated by regular communication between health service directors, managers of the palliative care service/s and specialists employed by the organisation. Consistent models of care within each region of Victoria are what many palliative care services are striving for to provide a distinct framework to support specialist palliative medicine practice. Clear expectations of the Palliative Medicine specialist role to meet the needs of the rural community were viewed as integral to ensure smooth running of the service.

…you need supportive governance and a structural framework across the region… certain guidelines or rules for how it will operate and what the KPIs will be, but also regularly revisits those in light of the service that's being provided and the resources we have in terms of personnel… (Palliative Care Service Manager).

And

To have a resident pall care specialist here it is important to have all the systems in place so they know what they are getting into, communication about what is expected of them, what their role is … (Palliative Care Service Manager).

Service Integration

A service model that meets the needs of the community incorporating home-based/community palliative care services, inpatient consult services and a palliative care in-patient unit (hospice) are the three core components viewed as fundamental to a comprehensive palliative care service. For Palliative Medicine specialists this ideally involves an integrated health service that delivers a model of care seamlessly linking community, inpatient hospital and hospice care. A continuity of care practice model designed to respond to the changing needs of the patient and family was viewed as

professionally satisfying model to work within. Being able to provide holistic care and care for the patient in their own home "to meet them on their ground" was as one specialist highlighted satisfying and beneficial for all involved.

...we've got the community service, the hospital consult service and the palliative care in-patient unit and all those things dove-tail… it depends on the complexity, the ability, where's the right place for the patient to be at that time (PMS).

The continuous care and the ability to follow patients across all settings as their needs required was an attractive aspect of working within an integrated regional service.

… our community service, our inpatients, the consultation service they are all under the same umbrella so it's very much a handing over of patients from one part of the service to another which is much easier than say in metropolitan areas where the community services might be independent from the hospitals (PMS).

Multidisciplinary

The benefits of a multi-skilled workforce with the ability and confidence to manage the complexities that may be involved in caring for people with a life limiting illness further enhances service attraction. A multidisciplinary team approach is widely felt to be the hall mark of a comprehensive palliative care service with each discipline providing insights and impacts to meet the needs of patients and their families. It is also the recognition that various skills are needed to provide holistic patient-centred care. As one Palliative Medicine specialist from a well-resourced centre states:

I think it needs to be multidisciplinary which it is here both in terms of medical and nursing staff, but also allied health and importantly psychosocial support with psychology and pastoral care and social work.

Communication and fostering good working relationships was felt to be important for cohesive, consistent and optimal management of patients. Regular, multidisciplinary team meetings are an important aspect of palliative care practice utilised to facilitate this process. There is recognition too amongst Palliative Medicine specialists as previously highlighted, that they themselves are unable do their work effectively without the support of skilled GPs, nursing and allied health staff.

One of the key things about pall care is being able to work in a team and having the other members of the team there would be critical, nursing, psychology, social work and other allied health team members as much as possible knowing there are going to be some limitations depending on the size of the hospital and centre I work in. I think it is impossible to do pall care on your own as a doctor (Advanced trainee).

And

…I think that what we actually do for patients when they get admitted is not just the work of one person. You really need in these complex cases to provide the care and support from a whole lot of angles to actually get the person comfortable and their family to be comfortable and not distressed (Visiting specialist).

Health services that supported multidisciplinary approaches in their care of palliative care patients was acknowledged as providing a supportive framework to provide effective and sustainable specialist palliative care practice.

2. Personal/Social Networks

Lifestyle, spouse/partner employment opportunities, education for children, close proximity to family and friends were consistent elements of personal satisfaction important for palliative medicine specialists. Several mentioned the importance of having a work-life balance in place to ensure career longevity and to be able to take leave to accommodate family needs. Family contentment and happiness in the region was ultimately a key determining factor in decisions to stay in a region long term.

As one Palliative Medicine specialist stated:

it's actually remarkably easier to work in the country in the sense that if you look at where I was living I was three minutes from both hospitals, four minutes from the palliative care unit and when people said oh God all you do is these long trips, yeah but I don't have to do a three-quarter hour commute from home to work in heavy traffic every day and that's an advantage.

Widely recognised challenges were the employment opportunities for spouses/partners which could be quite variable from one rural region of Victoria to another. Support for partners was highlighted as a very important issue in consideration for relocation due to the fact for some partners the expectations they have of their own careers in country areas is often difficult to meet. Lack of or dissatisfaction with spousal/partner employment would most likely result in the family moving back to a metropolitan location. Availability of good accommodation was also an issue in some rural regions. Some specialists chose to live outside the town/city in which their practice was located to avoid the 'goldfish bowl' phenomenon and provide some distance between professional and personal life.

Important the spouse is happy too. We did have someone who was doing a project and we assisted her husband with employment…she was happy where she was but her husband wasn't happy, so they went back to Melbourne (Palliative Care Service Manager).

The quality of education available especially in the secondary schooling years was considered important for continuing to live in a region as was being able to pursue interests and recreational activities. Proximity to a large city such as Melbourne, being a commutable distance (i.e. under two hours) was frequently mentioned in interviews by junior specialists as vital. Being able to readily visit family and maintain connections with friends was central to their personal happiness. Transport (rail service) accessibility to Melbourne was also mentioned as a crucial feature for practice location. In regions where these services were limited this was seen as a significant detracting feature for permanent relocation.

All my family and friends are based down in Melbourne. Often we would be coming down to Melbourne on weekends for social things and that is different compared to someone who is born and bred in this region that has their social networks there. I think that's an important consideration for being somewhere that is commutable to where that is so if that's in Melbourne (PMS).

And

You're talking about opportunities for spouse workwise or school opportunities for children, the opportunities are proportionately less in rural regions so the opportunities need to significantly outweigh the short term costs of moving away from your social network or possibly your family network (PMS).

3. Environmental Challenges

Distance

The distance involved in visiting patients in their home and to maintain extended family/friend connections was viewed as a significant challenge of rural practice. Furthermore, the time and fatigue associated with travel was identified as a difficult aspect of rural practice. Technological limitations such as availability of equipment for use in patient's homes for telehealth practices and the unreliability of internet connections/service drop-out or 'black-spots' was cited as barriers to delivery of care over vast areas.

So it's actually very difficult, one of the big challenges really is trying to deliver care over such a large area and trying to be responsive when in actual fact you can't be because we either haven't got the technology or the time to do so (PMS).

And

The limitations of the distance because sometimes you felt you weren't 100% sure as to what was exactly going on with the patient. If you were getting a call maybe 4pm on a week day there is no capacity at all to be able to duck out and see that patient (PMS).

Interestingly too, there was a disparate use of telehealth/telemedicine type practices to service more remote regions. Whilst some services embraced telehealth others were more reluctant to embed telehealth routinely in their practice. Lack of familiarity with equipment, reluctance to embrace new technology and the preference for face-to-face consultations was frequently mentioned as reasons for its underutilization as a form of palliative practice support for remote areas. The following comments illustrate the differences in use.

get the technological hurdle sorted out and then - it means that they can sit with their patient in front of a screen, talk about their syndrome, get a multidisciplinary input and treatment plan…it may not be quite the same experience of sitting in the room but if it's 90 per cent … not going to travel five hours probably for one clinical appointment (PMS).

Well we don't use it - I don't think we use it very well and I think we could use it a lot better…most of our rural hospitals now have telehealth systems. (Palliative Care Service Manager).

And

And also, the frustration, I suppose, is sometimes you get a phone call from a doctor in a far flung place and you think I'd love to be able to eyeball that patient and that's where telehealth needs to develop more…(PMS).

Videoconferencing in some regional areas was seen as effective especially for multidisciplinary review and education. Informal practices such as using iPhones to send pictures to Melbourne of wounds for immediate specialist advice was a strategy used to overcome technological limitations in outer regions. Telephone support however remained the main form of ongoing communication and specialist support to health service workers in regions where visits were restricted and the limitations of this (secondary consultation) were recognised.

It doesn't allow assessment of the patient from Melbourne …as it always goes through the intermediaries or the nurses and so the patients aren't actually at those conferences. In an ideal situation they would be (Visiting specialist).

Operational Culture

The operational culture of the health service was seen to either facilitate or hamper specialist palliative medicine practice. For regions without a constant Palliative Medicine specialist presence resistance to specialist intervention was mentioned as one of the hurdles faced. Fear of role erosion and threat to practice for some GPs was a concern, as they had been managing the care of dying patients for many years without specialist support.

…we have to be very careful about not stepping on other colleague's toes and not taking over etc., but I think it's magnified in a regional location and you have some GPs who, you know, you can't prescribe a single opiate for their patient. They hit the roof. And you have others who won't refer at all and then others who will and then – yeah, it's very patchy, the culture towards palliative care is very patchy and I think you need to come with a very humble approach that – a lot of these GPs have been doing that for 20 years (PMS).

The difficulty with a lack of constant presence in the region, the variable knowledge of GPs in palliative care practice and the resistance to outside intervention made implementation of care as one visiting specialist explains difficult.

… the culture in larger tertiary hospitals would not do that…being referred very late when somebody has had challenging pain for many months and when oncology has been involved, or the general physician has been involved and they had the acute pain service involved and its only after the persons acutely delirious or looking like that they are dying that we have been asked to be involved…was difficult

And

Some doctors have relatively little experience in palliative care and feel quite nervous in prescribing some of the medications we would use more commonly… I think a few GPs would still view palliative care as more of a nursing led speciality and not fully recognise that it is a medical specialisation (PMS).

Proportionately, cultural resistance to palliative care practice can be explained as one manager highlighted by a lack of awareness and understanding of the specialist interventional role for complex patients especially in rural areas not used to having a specialist presence. As one Palliative Care Service Manager pointed out health staff was often unsure of how and at 'what point' to incorporate palliative medicine specialist intervention into the care trajectory of a patient. Cultural change in some regions was thus viewed as essential to embrace palliative care specialisation and utilisation.

Another role I would see of the pall care physician is to change the culture influencing the hospital palliative care approach….up-skilling GPs, educating them about palliative care… changing the culture in the hospitals about palliative care.

Limited Resources

In addition to the tyrannies of distance, access to various resources especially in more remote areas of Victoria remains a challenge for rural medical practice. Specialist palliative care workforce supply of psychology/psychiatric and allied health professionals is limited in many rural regions. For Palliative Medicine specialists this was identified as a significant gap in providing comprehensive patient care as often patients required intervention outside their expertise.

…the psychiatric stuff is very difficult because I think they have very little psychiatric support there and so trying to get the right support for that person is very difficult and that's – you know, when it's sort of a severe issue it's out of my specialty area, so I can feel a bit stretched (PMS).

Other resource gaps mentioned included specialist neurological or anaesthetic type pain relief procedures measures requiring transfer of patients to metropolitan tertiary centres; the lack of palliative care inpatient hospital beds serviced with appropriately trained staff ; the lack of hospice facilities in some areas; and access to appropriate medications in more remote regions. As the following examples highlight:

I think you really need some – an in-patient bed option that is a palliative care unit. So that means having sort of specialist nurses who are, you know, familiar and trained with palliative practices… and some equipment, … so they actually have syringe drivers and the drugs on hand and also some of the allied health support … social work, pastoral care, etcetera (PMS).

The drugs we wanted to use were not available in Ouyen so the palliative care nurse drove from Mildura to Ouyen with the drug and back again to ensure the patient's comfort. He eventually died in comfort (Visiting specialist).

And

So for example we don't always have adequate hospice beds and then we cannot actually manage people adequately on the wards because we don't have the resources on the wards to manage people in the way that we would in hospice (PMS).

4. Sustainability

Resources

Access to resources as illustrated has significant impacts on palliative medicine practice in regional/rural Victoria. Mentioned is the importance of resource availability such as clinical services (inpatient hospital beds/hospice facilities) with trained staff that is seen to make some regions of Victoria more attractive to set-up practice than others. As many Palliative Medicine specialists have intimated the ability to practice effectively with resources and supports in place is a determining factor in whether to relocate and remain in regional practice. Resources needed for specialist palliative care practice and to meet outer regional community needs is further highlighted by the following Health Service Director comments:

…with the right resources there is a potential for a full time specialist and we could do a lot more in terms of the aged care facilities and even within the hospital because not every patient who needs pall care comes through the pall care program…we can we try and get them into that stream rather than just dying on the wards

And

I would like to facilitate more support for patients to stay at home and only come into hospital if they really need to… I am not quite sure we have got systems and processes set up to have appropriate pain relief set up in the home and often that is the reason why people come into hospital- for appropriate pain relief

Improvements in key regional health service capacity (local hospital, oncology and radiation services) is however being seen to have positive flow-on effects for recruitment (quality of health service staff) and changing perceptions of rural work. As one Palliative Care Service Manager stated "if you build it they will come". Regional capacity building to support palliative medicine practice is also

being initiated in regions without resident specialists. Strengthening the available workforce capability is a key strategy for regional sustainability especially where environmental factors make one region less attractive for recruitment compared to other regions that may be geographically better placed or have greater local attractions. As one Palliative Care Service Manager states:

…to the NP model we couldn't recruit NPs so we are up-skilling NP candidates that were living in the region and the same with allied health we are up-skilling allied health to get some pall care qualifications. That's a sustainable model that is proven time and time again and that is the approach we are taking in pall medicine.

For the more remote regions of Victoria the visiting specialist model is viewed as a more sustainable economic option that meets the demands of smaller populations. In addition, outreach models from key regional hubs are seen to be operating successfully in some regions to meet community needs.

Sustainability for Palliative Medicine specialist roles also crucially involves maintaining a balanced work load for those in rural practice with adequate staffing, backfill for leave requirements and maintaining a pipeline of specialists to replace those who relocate practice or retire. It also requires forward planning by the health service as one Palliative Medicine specialist highlights to actively seek and target potential graduates to consider rural practice especially if they have a rural background or a commitment to rural practice.

… post graduate registrar students we try and sway one or two to think about palliative care …now two are pursuing specialist training…recruit someone from the area who obviously wants to stay here and live here… you know you are going to keep them long term.

Providing positive rural training experiences is seen as an important aspect of fostering interest in palliative care. It is those experiences under the tutorage of a Palliative Medicine specialist in rural practice that can be critical as one specialist highlights in career choice and direction.

…when I was training to be a doctor was quite pivotal, he was a very good role model, the way he interacted with patients. He was the sort of doctor I wanted to be. But I also wanted to be a country GP and do general practice and palliative care…I had to make the decision if I didn't do it at this stage of my life I would never do that training later in life so I went and did the 3 year training in Melbourne and commuted.

Data Collection

Collection of data to substantiate the need for Palliative Medicine specialists in rural Victoria is also being actively undertaken in a number of regions. The importance of evidence-based practice for funding/resource support for regional/rural palliative care service sustainability is as stated by one Palliative Care Service Manager, essential. Collection of data related to practice activities is viewed as an important aspect of the Palliative Medicine specialist's role that needs to be emphasized in palliative medicine training programs for regional specialist practice viability.

A huge problem influencing government is that the data is such a mess so we record everything that the visiting specialists does, every MDT meeting, graphs of what symptoms are being discussed… which is even good to show someone wanting to come to the region.

And

…if you don't have good data collection processes then their efficacy can't be proven or demonstrated so… undermining the whole system including their position.

Community Support

Community support for the role is essential for sustainability. Genuine community ownership of the process in developing palliative care service models to meet the needs of the region is seen as vital.

One of the main things is seeing what the community actually needs rather than going in there and saying this is what I am going to do because that will be neither helpful or sustainable so trying to work with what's been happening on the ground and build a model of care that is appropriate is important (Advanced trainee).

Realistic expectation of the Palliative Medicine specialist role is also seen as essential for practice viability. Equally important is community understanding that not all patients require specialist intervention. This has been highlighted as the following specialist states, to ensure optimal use of specialist skills and fostering continued confidence in generalist care available.

…personally I worry a little bit that we are deskilling general practitioners and other community health providers in terms of managing patients… And I think it comes back sometimes to the difficult balance between patients who are managed with a palliative intent and patients who need specialist palliative care…I don't personally think those two things are the same, but I think it's a difficult balance to find.

Training

The supply of Palliative Medicine specialists to meet regional needs is a concern for regional health service providers. Flexible models of education delivery for regional/rural areas in which doctors can access training locally in addition to further flexible supervisory and accreditation requirements by the College to enhance regional hospitals ability to support specialist training, are some views put forward to encourage regional up-skilling. It is also seen to enhance exposure of trainees to rural practice and maintain a pipeline of palliative medicine specialists for regional sustainability. As the following comment highlights:

To support training we have to have accreditation to do that. We possibly could have one pall care physician here and a registrar…that would need to be supported by the College (Health Service Director).

And

The feedback from the board was if the education was done in the region rather than in Melbourne you are much more likely to get them. If you really insist on regional sustainability…you need to find a GP that works here and train them up (Palliative Care Services Manager).

Training and ongoing education opportunities provided in local regions is seen as not only enhancing workforce capacity and accessibility for ongoing professional development but recognition of the value of the expertise that lies in regional/rural Victoria.

For registrar training in some regions of Victoria without a palliative care resident specialist and local model of service to support physician training, the key barriers identified by one Palliative Care Service Manager relates to local health service agreements, equity of access and funding. Difficulties of attracting trainees to less well established specialist palliative care health services areas that are more distant from Melbourne is also a noted challenge.

…to actually attract a specialist over there it needs to be a well-established unit … There needs to be the ability to support a specialist with some trainees as well. And again, you know if we wanted to build trainee capacity we would need to actually have supervision first. So I think it's a 'chicken and egg' issue. (Health Service Director).

Establishing models of practice in these regions to support physician training within local hospitals/communities is thus seen to be important in building palliative care specialist services and one that holds great potential.

Section 4: Discussion

The two phases of this project, a review of the literature and interviews with key stakeholders (Palliative Medicine specialists and those involved in the management of palliative care services) in regional/rural Victoria provide evidence for the use of a multifaceted approach that gives due consideration to the professional, personal and environmental context in which care is delivered. The MABEL framework underpinning project direction recognises the elements (financial, professional/organizational, social and external context) intersect and influence professional satisfaction and hence retention. Attention and consideration to the impacts of all these elements is needed and is supported by the findings of this project although the emphasis and weight given to the importance of some of these elements is distinct for specialists as opposed to needs of rural general medical practitioners for which much of the research (noted in the literature review) including MABEL research activities highlights. Remuneration for the role for example, whilst important was not found to be a central tenet of professional satisfaction expressed in interviews conducted. This may be explained by the award for specialists in place and the incentives applied by health services such as a car to support travel requirements or rural loadings for outer regions to support physician relocation.

Of note was the fact that 64% of palliative medicine practitioners were above 40 years of age with an average of 5 years in specialist practice. This may highlight that palliative medicine is speciality that is chosen after some years of medical practice and life experience to sustain self with its unique demands hence for a young medical practitioner it may not be viewed as an attractive initial career choice. The years of specialist practice is consistent given it is a relatively new field of speciality practice (training available since 2008).

Of the sample of resident Palliative Medicine specialists interviews 45% were of rural origin and whilst important to enhance settlement and realistic expectations of the role it was clearly not the only determining factor in choice of a rural practice location for all specialists. Consistent with previous studies that have examined motivating factors for medical practitioners to practice rurally 80% cited positive rural experiences during medical training/practice, the variety and scope of practice, lifestyle, proximity to a metropolitan centre and population size as being important in choice of practice location (Toguri et al., 2012, Walker et al., 2011; Dolea, 2009; Henry et al. 2009). It is evident from project findings for those specialists most satisfied in rural practice that having peer support/critical mass, collegial support, health service and MDT support, an opportunity to work within an integrated palliative care service model of community, inpatient hospital and hospice that allows a seamless model of care where patients can move freely from one level to the next as care or choice requires, and service model that offers regular outreach support to meet community demands, are the many multifaceted professional desires being met on several levels. Reach within the community is widely viewed as important for ongoing role support. Providing a forum for genuine community participation in this process of specialist palliative care service delivery is recognised as crucial for role sustainability (Wakerman & Humphreys, 2012). Engaging support from general practitioners and other regional medical specialists is a central tenet identified for practice viability and it is through practical onsite demonstration of benefit to patient care for complex patients requiring specialist intervention and fostering strong communicative and collaborative relationships that role benefit is acknowledged and threat to their practice reduced. Actively promoting the central role of GPs in the care of dying patients has been found as an effective strategy to facilitate this process (Mitchell & Price, 2001).

Undoubtedly a presence of Palliative Medicine specialists in the community where practice strategies are geared to meet the needs of the patient, where evidence of practice can be seen on the ground rather than delivered remotely, coupled with well-structured accessible education for healthcare providers that is tailored to their needs and where frequent communication between all

providers is transparent to alleviate confusion or misinformation with regards to role impacts, are essential ingredients for role acceptance. Although working within specialist palliative care teams and access to multidisciplinary allied health professionals to support palliative medicine practice is important and are long-term goals for many regions, a sustainable strategy clearly identified to fill this gap is to strengthen the service capabilities of local providers (i.e. GPs, nursing, psychology/psychiatry and allied health) through education and training support. Similarly, Wakerman and Humphreys (2012) have identified the need to identify persistent training gaps for these disciplines and for the need to provide better integrated and expanded programs to improve geographical coverage with a 'view to creating team-ready graduates'(p.16).

Strategies in place that also enhance ongoing communication between palliative care service staff needs and Health Service Employer/s, targeted at a number of levels (professional and personal) simultaneously, also provides an ideal practice environment. For those well-serviced regions in close proximity to Melbourne with clear and transparent models of cohesive and coordinated palliative care practice this is clearly the elements that make a viable and sustainable service. Regions without the similar level of service availability or attractive environmental characteristics more distant from Melbourne (i.e. more than 2 hours), the challenges to recruit and retain specialists are as expected, greater. However, it is recognised that building health service infrastructure in regional hubs is having a positive slow and steady flow-on effect of attracting quality staff for the region and important for long-term health service workforce retention. Also noted is the fact that the majority of Health Service Directors interviewed are relatively new to their role (less than 3years) which may reflect a local organisational response to focus on improving leadership and strategic direction as health services develop and expand in regional areas.

A critical mass of specialists to provide professional support, a manageable workload that provides backfill for leave/CPD to prevent work overload and burnout, and working in a supportive like-minded team are unmistakeably the most consistent findings of the project that support and sustain palliative medicine specialists in practice. A combination of factors, the nature of the work (distress associated with patients dying) and the fact that for many communities in rural Victoria this is an unfamiliar and not well-entrenched specialisation in practice is the likely reason for this emphasis amongst those interviewed. Although research to date is not well established in the needs of Palliative Medicine specialists, it is patently clear from the project findings that working within a team environment that acknowledges and supports the role is essential for professional satisfaction and is supported by Joyce et al. (2011) national longitudinal survey of doctors showing a consistent strong relationship between professional support and job satisfaction in enhancing retention in rural areas.

In regions of Victoria where specialist frameworks of practice are not established the need for peer support and to establish creative practice frameworks where a minimum of two specialists can be employed in flexible part-time roles that meet their needs as well as those of the health service are mandatory. A greater Palliative Medicine specialist presence within some regional hospitals is also needed for role support and to meet ongoing patient care needs. It is an important consideration when decisions are being made for development of palliative care consultancy services especially in regions distant from metropolitan centres for their ongoing viability. Conjoined appointments academic and clinical (with universities and metropolitan tertiary health care centres) and dual specialisation credentialed medical professionals (e.g. oncology/gerontology and palliative care) are examples of some creative strategies being utilised in some areas to foster and maintain professional links, supplement part-time employment and meet health service needs. Facilitating opportunities for professional development in creating established links with metropolitan tertiary health centres ensures rural specialists feel engaged, connected and valued for their contribution to palliative medicine specialist practice. The enhancement and support of data collection in all regions of Victoria will assist in facilitating a stronger depth of evidence based on practice activities of

Palliative Medicine specialists to guide strategic directions of services for care of patients with a life-limiting illness.

Meeting the social and personal needs for relocation is of central importance to Palliative Medicine specialists and recognised by Health Service Employers. Attention to spouse/partner employment goals, community integration, access to quality education for children especially in their secondary schooling years and accessibility to extended family/friend networks are the main areas consistently highlighted in participant interviews. A 'bundle of incentives' as emphasized by Humphrey and colleagues (2009) is needed to recruit and retain Palliative Medicine specialists to rural regions with attention to the key areas (financial, professional, social and location) is especially relevant in building consultancy services in regions that are more distant from Melbourne and where services may not be well-established. Competitive salary packaging that includes accommodation assistance, a car for travel requirements of the role, fee assistance for education of children if required to access education in a larger centre, return airfares to place of origin, assistance with professional development fees and assistance with family employment (including retraining needs) and flexible family friendly work arrangements is an example of a 'bundle of support' that may facilitate relocation to more distant regional/rural areas to outweigh the opportunity costs (RDAA, 2009).

It is of concern that telehealth practices to facilitate and support specialist palliative medicine practice in distant and remote regions is reported by project participants as ad hoc and underutilized in some regions. Conversely it is well established in others. Whilst telehealth initiatives are generally welcomed by some Palliative Medicine specialists and service providers difficulties with ease of use, restricted times for availability, a reluctance to incorporate the technology as a routine in practice and ready access to equipment (e.g. ipads) to use in patients home, unreliable internet access issues and the preference for face-to-face contact are some of the barriers impeding use. Currently, in some regions telehealth practices such as videoconferencing is being used effectively to facilitate multidisciplinary case conferences, to support ongoing education and in some areas within patient homes to facilitate contact between specialists and their patients. Telehealth benefits found in palliative care settings in the UK include interactive case discussions, consultations and assessments, education of staff, improvements to after-hours service, faster access to health professionals, improved patient and carer experience, better use of time and improve efficiency of service delivery (Kidd, Cayless, Johnston & Wengstrom, 2010).

Greater support and education to facilitate its use to encourage telehealth practices are important to support specialist practice from distant sites and to ensure more remote patients have access to specialist opinion and are able to remain in their homes if desired. Visiting palliative specialist frameworks in some outer regions will be better supported through greater uptake of telehealth practices to reduce frustrations associated with current secondary consultation practice using telephone contact in which the patient is not present and cannot be 'seen' or spoken to which is essential for comprehensive assessment and intervention planning. It also allows for greater satisfaction in remote advice given. In addition, telehealth is important for CPD to support and mentor palliative medicine practitioners and facilitate links and connectivity with metropolitan centres to help sustain practice (Bonney, Knight, Mullan, Moscova & Barnett (2015).

A final outcome from project findings is the need for further flexible models of specialist palliative medicine education delivery that promotes greater exposure during training to rural practice settings and enables regional/rural general practitioners opportunities to pursue specialist qualification locally rather than attend all requisite education in Melbourne. Currently as most postgraduate specialist medical education is based in large metropolitan centres it is important that further efforts to deliver creative modes of education that include webinar, podcasts and establishment of online learning management systems that enhance webcast use or 'Blackboard' become embedded in post graduate training programs to make education more accessible for rural

workers. Establishing 'virtual clinics' of clinical education (to support medical training programs) that is transmitted to rural training sites is one telehealth strategy currently being evaluated in Australia (Bonney et al., 2015). Outcomes from such trials will be important to inform palliative medicine training programs of strategies that can be used to enhance provision of rural based education and training.

Furthermore, flexible accreditation approaches for rural training experiences through the exploration of alternative models of supervision to support and extend regional/rural specialist practical training by physician and general practice Colleges is vital to maintain a pipeline of trainee specialists and reduce current restrictions on rural training pathways (Arvier et al., 2007). As the pursuit of postgraduate education often coincides at a pivotal time in a doctor's life both professionally (mentor-trainee relationships) and personally (life partnerships, work opportunities for partners, purchasing homes, schooling arrangements etc.) it is important for greater regional postgraduate education opportunities to be available at this time to encourage rural settlement and build upon the investments made in medical undergraduate education in rural Australia (Hudson & May, 2015).

4.1 Strengths and Limitations of the VRRPPC

The main strengths of the project resulted from 27 stakeholder in depth interviews that provided a rich penetration and insight into the professional and social supports needed to support specialist palliative medicine practice in regional/rural Victoria. The diversity of the sample provided a good representation of all stakeholder groups and the interviews consequently yielded a wealth of descriptive information. The literature review also was fundamental to strengthen internal validity and reliability of results. Given that the interview sample was purposive and the sample size relatively small, there is a risk of sample bias. Wider stakeholder consultation through surveys may be an additional strategy useful for future research in this area.

Section 5: Conclusion & Recommendations

The vision of increasing workforce capacity of Palliative Medicine specialists throughout Victoria requires a focused and continuous multipronged approach to meet the professional and social needs required to attract and retain specialists in rural Victoria. Clearly in some well-developed regional services the models in place are supporting the needs of specialists with ongoing evaluation of sustainable practice and community needs regularly incorporated in practice.

The key attributes that successful region models have in place to support the professional and social needs of Palliative Medicine specialists including the ability to support and supervise training, is the capability to meet these needs at a 'number of levels'. At the individual level professional support that enables use of a variety of skills, encourages autonomy, enhances peer and collegial support, CPD opportunities and social supports to meet family needs (e.g. facilitating employment for partners) are to a great extent being met through active and committed health service activities in these regions. Strong collaborative relationships between Palliative Medicine specialists and medical executive staff that includes being involved in a wide range of relevant organizational activities for planning and care implementation is for example, ensuring ongoing professional needs are being met. Targeted selection and active recruitment (shoulder-tap) of potential palliative medicine candidates that show an interest/commitment to the region exhibiting characteristics that include flexibility, realistic expectations, enhanced communication skills and adaptability to meet community needs are strategies being utilised by these health services to meet ongoing recruitment and retention needs.

At a micro (workplace) level the leadership and support of the regional health service in terms of a commitment to a strategic palliative care direction to meet the increasing complexity of care required by an ageing population with frameworks that encourage supportive specialised palliative care services with trained staff are important to support and validate the Palliative Medicine specialist role. Health services that are vigilant and proactive in assessing the 'needs' of its workforce and population in an ongoing manner, develop workforce planning measures to fill potential gaps/vacancies, that revise and review strategic directions based on collaborative relationships within their communities are having more success in recruitment and retention. Communities that invest in well-staffed home-based community services, inpatient hospital and hospice facilities that are interconnected and linked within one overarching framework to provide seamless care sets an ideal model for palliative care specialist practice. A model that ensures all parts of the services talk to each other and enables specialists to keep within the loop of patient care for care continuity and congruence. Project activities also recognise that although the emphasis for development of palliative care services has been traditionally community-based it is also important in some regional areas to build and enhance the palliative medicine presence in key regional acute hospitals (e.g. designated beds with trained palliative care staff). An active specialist palliative medicine presence is imperative in acute hospital environments (the central regional hub) to encourage collegial relationships and early referral from other physicians and surgeons within the health service; to optimise patient care during their care trajectory across settings; to enhance community and health service staff awareness and acceptance of the specialist role; and to facilitate enhanced home-care discharge planning.

Furthermore embedding palliative care within a wider health service framework that include rehabilitation, community and aged care services with similar paradigms under one domain of service is a supportive, facilitative and attractive collegial working structure for some organisations. Successful models of regional practice also have established support for key outreach remote regions through regular visitations and empowerment of staff through education and ongoing support. Registrar training within such environments is also enhanced through the onsite specialist supervision available and variety and depth of experiences offered.

The evaluation of regional models of successful palliative care practice or similar oncological services in place is a crucial step to facilitate and guide the development of palliative care service models in other regions of Victoria. It is important for regions without a resident Palliative Medicine specialist to ascertain from other specialist disciplines (e.g. oncology) the strategies that have enabled them over-time to evolve and embed their practice with a critical mass in regional areas and to learn from their experience. An analysis of the community needs in each region is also imperative to facilitate this process to ensure models are adapted to the context in which care is provided. Such evaluation would also assist in providing evidence for wider macro level support at a health system/government level.

The rewards of rural practice can be great and the potential for improved palliative care practices benefiting both clients and health service providers ensuring equity of care for rural Victorians is a vital outcome.

5.1 Recommendations

The following recommendations are suggested to enhance attraction to and sustainability of specialist palliative medicine practice in rural Victoria acknowledging the influence of the VPMTP role in prevocational and vocational training outcomes, Palliative Medicine Specialist Groups (PMSG), employing regional Health Service processes and Department of Health, Policy and Funding implementation strategies (see Figures 4-8).

1. Palliative Medicine Specialist Workforce Requirements:

- A minimum of 2 resident Palliative Medicine specialists (EFTs as demand requires) in all five regions of Victoria to enable sharing of practice responsibilities, on-call and leave.
- Consideration to flexible work arrangements by health services to enable practice sharing within a region. For example, shared clinical roles between metro/rural, joint clinical/academic appointments with a University and joint clinical roles (i.e. oncology/geriatrics and palliative medicine).
- Adequate supervision /mentoring of junior specialists are essential and may require input from other centres.
- Explicit position description that include bundles of incentives (e.g. flexible family-friendly practice, competitive salary package) that clearly articulate roles responsibilities and processes in place for role implementation and support.
- Increased presence/role of Palliative Medicine specialist across settings (i.e. in the community and in key regional hospitals) to build collegial relationships. This is also important for early referral, optimal patient care to meet complex care needs and for appropriately supported patient discharge needs.
- Education and support for dedicated use of telehealth practices to assist remote palliative medicine care delivery and facilitate multidisciplinary approaches to care.

2. Health Service Requirements:

- A trained and skilled multidisciplinary team of professionals that work together to optimise patient care outcomes is the cornerstone of a comprehensive palliative care service. Support given for regional capability to up-skill (GPs, nursing, allied and mental health care staff across settings) is an effective solution to address shortage and support specialist palliative medicine practice. It is important education is offered in a variety of ways that include local and remote delivery to encourage uptake and ensure skills are at a similar level found in metropolitan centres. It is essential that staff developing skills in palliative care also have access to ongoing education support and are encouraged to use skills through active involvement and referral of patients to their care. A process that enhances team structures

in each region is essential and telehealth practices could be used further in some regions to facilitate this process

- Infrastructure support and education for routine use of telehealth to support practice roles and to enhance remote patient care and service delivery is an important immediate goal that needs to be addressed both in regional Victoria and metropolitan Melbourne

- Data collection frameworks (monitoring and evaluation) to support evidence-based specialist palliative medicine practice. Strong data collection frameworks that include community need analyses will provide a sound foundation for model development/enhancement.

3. Palliative Medicine Specialist Training Requirements:

- It is essential the VPMTP in conjunction with the Chapter of Palliative Medicine at the RACP commence discussions to develop further flexible and accredited clinical supervision and mentorship models for advanced palliative medicine trainees in regional/rural health services.
- A greater focus of rural palliative medicine practice in the curriculum of the Victorian Palliative Medicine Training Program (VPMTP) will enhance potential graduate choice of practice in rural locations. Building, lengthening rural rotations, mandating rural placement (e.g. in training terms 4 or 6), and providing greater opportunities for distance education through development of wider modalities of learning (e.g. videoconference, web-based learning systems) are strategies that will provide greater exposure to rural practice and provide rural doctors opportunities for specialist qualification.
- Targeted selection of general medical practitioners/physicians in rural areas (e.g. areas without a resident specialist) with an interest in palliative care who may wish to consider specialist or diploma qualification, with adequate support/incentives in place to do so and where support for training can be provided locally in addition to metropolitan training requisites of the training program is a strategy that needs consideration. A professional bundle of incentives to assist this process that includes back-up support for study leave is important to ensure the benefits outweigh the opportunity cost.

Figure 4: Medicine Training Pathways - Promoting Rural Practice

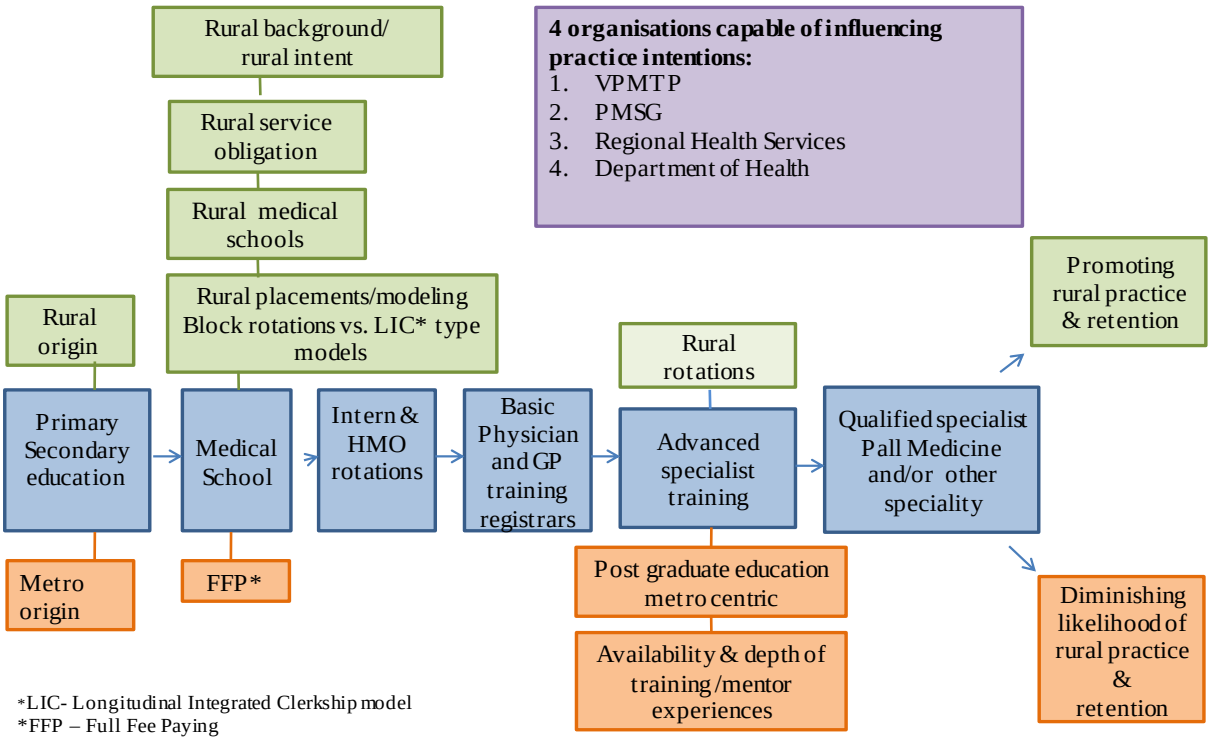


Figure 5: Recommendations: VPMTP (Speciality & Diploma Training)

1. **VPMTP:**

- Enquire of training history & target those rurally exposed/rural intent
- Build & lengthen rural rotations /mandate in advanced training
- Develop rural focus in curricula & include education re telehealth models of practice support/education.
- Develop & offer wider modalities for distance learning- videoconference, web-based learning support systems
- Promote & encourage GPs & training GP registrar Diploma position uptake in regional areas
- Promote alternative supervision/mentorship models- e.g. onsite & distant modes of support (in consultation with RACP)

Figure 6: Recommendations: Palliative Medicine Specialist Groups (PMSG)

2. (PMSG)

- Regional/rural based conferences
- Videoconference /web-based links for in-service education/networking/discussion groups (Blackboard)/peer support
- Consultation and clinical supervision
- Mentorship models- junior/experienced

Figure 7: Recommendations: Employing Health Services

3. Employing Health Services

- A minimum of 2 specialists in all regions (EFTs as demand requires)
- Flexible appointments- shared roles metro/rural, conjoined appointments clinical/academic, joined clinical (geriatrics/pall care)
- Explicit position descriptions- responsibilities/support available
- Family support & community integration
- Enhance metro linkages/CPD
- Promote/support specialist role in hospital & community
- Strategic directions for specialist palliative care services/service model
- Infrastructure support/education & designated time for telehealth activities
- Enhance development of MDT/specialist teams- regional up-skilling, strengthen palliative care team frameworks
- Data collection- embed monitoring & evaluation frameworks into delivery of specialist palliative care services

Figure 8: Recommendations: Department of Health (DoHHS)

4. Victorian Regional Health Services require DoHHS ongoing support for:

- Flexible palliative medicine specialist work contracts/incentives for rural practice
- Ongoing commitment to building regional comprehensive palliative care services – home, hospital & hospice integrated models
- Rural trainee financial incentives & support for local health service capability for supervision to maintain pipeline of graduates
- Regional MDT up -skilling & ongoing education
- Further development of telehealth infrastructure both metro & rural
- Support ability of VPMTP to offer wider modalities of education delivery & clinical supervision/mentorships for rural regions

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Section 7: Appendices

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Appendix B - Victorian Palliative Medicine Training Program (VPMTP)

The Australasian Chapter of Palliative Medicine (AChPM) specialist training (VPMTP) is a three year program at the advanced level and provides trainees with a broad experience in palliative medicine as well as cancer medicine and general medicine. Applicants can enter with a fellowship of a faculty or college approved by the Chapter or completion of RACP basic training. The specialist qualification awarded of FRACP or FAChPM depends on the pathway of entry. The AChPM also administers a 6 month diploma in palliative medicine (RACP, 2013).

Appendix C - Palliative Care Consortia Victoria

Palliative Care Consortium Agencies

Barwon South Western Region

Barwon Health (fund holder)
Colac Area Health
South West Healthcare
Bellarine Community Health
Portland District Health
Western District Health Service

Grampians Region

Ballarat Health Service
East Grampians Health Service
Wimmera Health Care Group
Ballarat Hospice Care Inc.
Djerriwarrh Health Service
St. John of God Hospital, Ballarat

Loddon Mallee Region

Bendigo Health (fund holder)
Castlemaine Health
Kyneton District Health Service
Sunraysia Community Health Service Inc.
Boort District Health
Echuca Regional Health
Mildura Base Hospital
Swan Hill District Health

Hume Region

Albury Wodonga Health (Wodonga)
Goulburn Valley Health
Northeast Health Wangaratta (fund holder)
Goulburn Valley Hospice Care Inc.
Benalla Health
Numurkah Health
Seymour & District Memorial Hospital
Ovens & King Community Health Service

Gippsland Region

Bairnsdale Regional Health Service
Bass Coast Regional Health Service
Central Gippsland Health Service (fund holder)
Koo Wee Rup Regional Health Service
Latrobe Community Regional Hospital
South Gippsland Health Service
Yarram and District Health Service
Bass Coast Community Health Service
Central Medicare Local
Gippsland Southern Health Service
Latrobe Community Health Service
Orbost Regional Health Service
West Gippsland Healthcare Group

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Appendix D - VRRPPC Logic Model

INPUTS	ACTIVITIES	OUTPUTS	OUTCOMES	MEASUREMENT
VPMTP executive **VPMTP Project oversight group** **External Stakeholders-**(e.g. Advanced palliative medicine trainees, key stakeholders in regional health services of Geelong, Ballarat, Bendigo, Shepparton, Albury/Wodonga & Latrobe Valley) **Resources**-funding, time, intellectual capital, office facilities, equipment, supplies, car, mileage, & accommodation **Research**- articles, publications, internet	• Project design & work plan • Project team: meet & communicate regularly • Literature & document review/analysis • Identify & engage key stakeholders • Conduct focus group, face-to-face or telephone interviews. • Data analysis & synthesis • Prepare/submit tasks, complete tasks, present interim reports, receive feedback • Prepare/submit final report	• Identification of professional and social supports that facilitate relocation & retention of Palliative Medicine specialists to regional/rural areas. • Identification of the barriers /constraints that affect rural specialist practice in Victoria • Development of bundled retention incentives to support Palliative Medicine specialists in rural practice. • An increased awareness of regional health service palliative care needs and expectations in regional/rural Victoria	1. Increased ability of each key regional health service of Victoria to recruit and retain Palliative Medicine specialists 2. Increased medical workforce capacity to deliver specialist palliative care in regional/rural areas 3. An increased ability to match regional/rural supervisory capability with the advanced palliative medicine training curriculum 4. Development of a supervisory model/s to support rural palliative medicine practice	Project design and work plan complete Project team meetings conducted fortnightly Interviews with advanced palliative medicine trainees A total of 24 interviews conducted in all six regional health services (4 per region) of Victoria between September & November Progress and final reports completed

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Appendix E - Stakeholder Questionnaires

A). Regional Health Service (Medical Clinical Service Directors/Palliative Medicine Specialists)

1. How would you describe the nature of your health service?
2. What is your role in this health service?
3. What is your connection to the palliative care services in your area?
4. What do you believe to be the most important elements of a comprehensive palliative care service? What are your needs?
5. Do you believe there will be a need for an additional palliative medicine specialist/s in your region within the next 5 years?
6. What were the factors that influenced you to be a palliative medicine specialist regionally?
7. Are you aware of your health service's current recruitment and retention strategies?
8. In your experience what health service strategies enable and encourage specialists to continue to work regionally?
9. How long do you intend on staying in this region? Why?
10. What are the most important elements of professional satisfaction that will influence you to stay in this region?
11. What are the most important elements of personal satisfaction that will influence you to stay in this region?
12. Are opportunities for professional development provided and supported by your health service?
13. Is the provision of professional development an important determining factor in continuing to practice regionally
14. In your experience what are some of the challenges you face living and working in a rural practice?

B). Workforce Retention Measures Used (Health Service Employer)

(e.g. Health Service Executive for Strategic Planning, Hospital Medical Services Director)

Measures believed important for recruitment and retention

1. What are you looking for in a medical specialist coming to work for your service?
2. Are there specific characteristics that you seek in 'matching' health professionals to your community?
3. What would be the impact of having a palliative medicine specialist in your region?
4. In your experience what are some of the most effective recruitment and retention strategies used to attract specialist physicians to your health service?
5. What other recruitment measures do you see as important that may not be currently implemented in your health service? What would facilitate implementation?
6. What resources and measures do you believe to be important for the retention and sustainability of a specialist medicine doctor and workforce in your region?
7. Can you tell me about some of the successful ways your health service provided education and training opportunities to medical specialists?
8. What professional development opportunities for medical specialists do you support and enable within and outside your health service?
9. In what ways is collegial support fostered in your health service?
10. What would your health service need to support specialist training in palliative medicine in the near future?

C. Focus Group Questionnaire

Brainstorm

1. Have you considered working as a Palliative Medicine specialist in regional/rural Victoria? Why/why not?
2. What professional elements would be essential and in place for you to consider relocation to a regional area to be a consultant?
3. What personal elements would be essential and in place for you to consider relocation to a regional area to be a consultant?
4. What factors would be important for you to remain living and working in a regional/rural location for the long term?
5. What do you perceive as the challenges of living and working in a rural region?

Conceptual framework

- **Financial/economic**- income potential, financial obligations
- **Professional/organisational**- skills development, opportunity for career advancement, serving health needs in the community, opportunity for professional experiences, increased autonomy, participation in rural training program, location of previous training
- **Social/Family-** influence of spouse, quality of education in schools, proximity of relatives
- **Environment** -community support, desire to live in a certain size population, desire to return to home town, culture, recreation
  (Humphreys et al., 2009b)