Beyond the Burbs: Specialist Palliative Medicine Training in Rural Australia – A scoping review

For the Australia and New Zealand Society of Palliative Medicine

RRIPM Project Team, January 2024

Acknowledgement of Country

ANZSPM acknowledges and pays respect to the Traditional Custodians of the lands and waters across Australia on which our members live and work, and to their Elders, past, present, and emerging.

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Key Abbreviations

Term	Definition
ABS	Australian Bureau of Statistics
ACRRM	Australian College of Rural and Remote Medicine
AIDA	Australian Indigenous Doctors' Association
AIHW	Australian Institute of Health and Welfare
AMC	Australian Medical Council
ANZSPM	Australia New Zealand Society for Palliative Medicine
ARST	Additional Rural Skills Training
ASGS	Australian Statistical Geography Standard
AT	Advanced Trainee
DOHAC	Department of Health and Aged Care
FARGP	Fellowship in Advanced Rural General Practice
FACRRM	Fellowship Australian College of Rural and Remote Medicine
FAChPM	Fellow of the Australasian Chapter of Palliative Medicine
FRACGP-RG	Fellowship of the Royal Australian College General Practice-Rural Generalist
FTE	Full-time equivalent
FIFO	Fly In Fly Out
HETI	Health Education and Training Institute
GP	General practitioner
JMO	Junior Medical Officer
MMM	Modified Monash Model
MSOD	Medical Schools Outcomes Database
NWP	The National Aboriginal and Torres Strait Island Health Workforce Strategic Framework and Implementation Plan 2021-2031

Term	Definition
NMWS	National Medical Workforce Strategy
PCA	Palliative Care Australia
RACGP	The Royal Australian College of General Practitioners
RACP	The Royal Australasian College of Physicians
RG	Rural Generalist
RMO	Resident Medical Officer
SIPM	Sydney Institute of Palliative Medicine
SPaRTa	Specialist Palliative Rural Telehealth Service
STP	Specialist Training Program
TCPM	Training Committee in Palliative Medicine
VPMTP	Victorian Palliative Medicine Training Program

Definitions

Rural

In this paper we use the term 'rural' to refer to regional, rural, and remote locations in Australia.

Several systems of classification exist to describe geography in the Australian context.

The Australian Statistical Geography Standard – Remoteness Areas (ASGS-RA) (2016) is a measure of relative access to services with the following structure:

ASGS-RA 1 – Major Cities of Australia

ASGS-RA 2 – Inner Regional Australia

ASGS-RA 3 – Outer Regional Australia

ASGS-RA 4 – Remote Australia

ASGS-RA 5 – Very Remote Australia

The Modified Monash Model classifies metropolitan, regional, rural, and remote areas according to geographical remoteness, as defined by the Australian Bureau of Statistics [ABS]. The MMM is used to determine eligibility for a range of health workforce programs, such as rural Bulk Billing Incentives, Workforce Incentive Program, Bonded Medical Program. MMM classifications are based on the Australian Statistical Geography Standard-Remoteness area (2016).

This scoping project uses the Modified Monash Model when describing rurality.

Modified Monash category (MM2019)	Description [including the Australian Statistical Geography Standard-Remoteness area (2016)
MM1	**Metropolitan Areas:** Major Cities accounting for 70% of Australia's population ASGS-RA1
MM2	**Regional Centres:** Inner and Outer Regional areas that are in, or within a 20km drive of a town with over 50,000 residents. ASGS-RA2 and ASGS-RA3
MM3	**Large Rural Towns:** Inner [ASGS-RA2] and Outer regional areas [ASGS-RA3] that are not MM2 and are in, or within a 15km drive of a town between 15,000 to 50,000 residents. For example - Dubbo, Lismore, Yeppoon, Busselton ASGS-RA2 and ASGS-RA3
MM 4	**Medium Rural Towns:** Inner [ASGS-RA2] and Outer regional areas [ASGS-RA3] that are not MM2 or MM3, and are in, or within 10km drive of a town with between 5,000 to 15,000 residents. For example, Port Augusta, Charters Towers, Moree.
MM5	**Small Rural Towns:** All remaining Inner [ASGS-RA2] and Outer regional areas. [ASGS-RA3]. For example: Mount Buller, Moruya, Renmark, Condamine.
MM6	**Remote Communities:** Remote Mainland areas [ASGS-RA4) and islands less than 5km offshore. For example: Cape Tribulation, Lightning Ridge, Alice Springs, Mallacoota, Port Hedland. Additionally, islands that have an MM5 classification with a population of less than 1,000 without bridges to the mainland will now be classified as MM6 for example: Bruny Island.
MM7	**Very Remote Communities:** Very Remote Areas [ASGS-RA5]. For example: Longreach, Coober Pedy, Thursday Island, and all remote island areas more than 5 km offshore.

Table 1: Modified Monash Model fact sheet. Source: health.gov.au. modified /modified-monash-model-factsheet.

Note: For the purposes of this report, rural training sites, or potential sites, have been identified only in MM3 – 7 regions. However, it is acknowledged that the MM2 (Inner Regional) classification is extremely diverse, including at one end of the spectrum two capital cities (Hobart and Darwin), as well as the outer suburban sprawl of the other capital cities, whilst at the other end of the spectrum it captures numerous rapidly growing centres that are distant from the major metropolitan centres and serve extremely rural communities, such as Albury-Wodonga. Furthermore, regional growth patterns mean that soon it is likely that some services currently in communities classified as MM3 will be reclassified to MM2 because of population shifts. Therefore, whilst the data in this report is presented for MM3 – 7 regions, in future RRIPM will adopt a pragmatic approach to defining rural services and will seek to develop and articulate principles to support this.

Contents

The system is not optimised for rural palliative medicine specialist training.

Executive Summary

This scoping review set out to determine the need and feasibility of establishing a Rural and Remote Institute of Palliative Medicine, to ensure a skilled rural palliative medicine workforce for the future.

This future workforce is important because rural populations require access to quality palliative medicine close to home, and existing services are vulnerable in the absence of a sustainable and well-resourced workforce plan. Mapping has demonstrated a palliative medicine workforce shortage and a significant maldistribution of specialist workforce between metropolitan and rural communities.

National policy reflects the need to address this issue, and the RRIPM project aim is consistent with this policy. The National Palliative Care Strategy identifies the role of palliative medicine specialists as important - not only in the delivery of care, but also in the support and building capacity of other providers in palliative care. (Department of Health, 2018). The National Workforce Strategy 2021-2031 makes clear that to achieve maximum benefit to the community, the medical workforce must be geographically well distributed. Furthermore, where a specialty can operate to their full scope of practice outside metropolitan centres, they will be expected to provide training in rural areas.

At a population level, the need for palliative care is growing faster than both the population and the total deaths. Well-resourced palliative care services provide cost savings to the health system overall. (KPMG, 2020).

The organisation of specialist training in palliative medicine has largely been focused on metropolitan locations. The review demonstrates a concerning lack of rural training opportunities, despite medical graduates and palliative medicine trainees expressing an interest in rural career pathways. Sufficient opportunity to train rurally does not currently exist. The barriers to rural training are multi-faceted and encompass both individual considerations and system issues. Geographic isolation hinders the ability of rurally based service providers to effectively network and support each other in the absence of a coordinating body, and this results in duplicated effort and missed opportunities in recruiting and supervising trainees.

National and jurisdictional funding to support rural palliative medicine training placements is unreliable and requires a stable horizon to develop the training pipeline. It is hoped that with growing demand on the health system, the value of quality palliative medicine will be understood as a positive investment reducing overall system costs, while adding significant human benefit.

Review findings provide opportunity to consolidate understandings of the critical issues facing rural palliative medicine, and to co-design a feasible response.

The establishment of a coordinating body, the Rural and Remote Institute of Palliative Medicine is widely supported in the palliative medicine sector. The opportunity for shared advocacy, linking and networking rural palliative care services presents hope for a more sustainable future. Specific opportunities for RRIPM to help services strengthen rural palliative medicine include:

- Expediting accreditation of eligible rural training locations
- Flexibility and modernisation of supervision requirements
- Tailored and targeted STP funding for RRIPM training positions
- Defining and teaching rural-specific competencies
- Introduction and development of Integrated rural terms
- Co-ordination between specialist and generalist training to ensure a functioning training pipeline for rural palliative care
- Networked educational offerings, mentoring and support including rural multi-disciplinary team members

The RRIPM involvement in streamlining and coordinating rural palliative medicine training will be essential to driving needed change across the national landscape. To support this rural pathway, proposed activities of a dedicated Rural and Remote Institute of Palliative Medicine will be co-designed with the sector and outlined in a consultation draft 'Future Directions – RRIPM 2025-2030 - The Mud Map'.

QUESTIONS FOR CONSULTATION

- Can you comment on the rural training pipeline, and how this can be operationalised to improve the sustainability of rural palliative medicine (p19)? What are the challenges and concerns in relation to the training pipeline that will need to be addressed?

- Can you comment on the *How to grow a palliative care service*: *Place-based model for the development of rural palliative care* (Figure 2)? How valid is it? What issues does this model raise, and how can they be addressed?

- Are there other barriers to enhancing rural specialist palliative medicine training that have not been identified in this report that you are aware of? What strategic opportunities or collaborations can support this agenda?
- Do you have comments or proposals in relation to the opportunities for training reform (p60)?

For consideration, please email any comments to rripmproject@anzspm.org.au up until Feb 13th, 2024.

Foreword

Palliative medicine in rural Australia is in crisis, the impact of which seems to be significantly under-appreciated by metropolitan colleagues.

The RRIPM project has developed in response to the struggles of rural palliative medicine specialists, who have identified the shared challenges faced in building much–needed and much-wanted services to provide excellent palliative care in rural communities.

The issues that are identified include:

- Lack of identifiable rural training opportunities, which means that we struggle to train people who want to work rurally, and frequently lose them when they are required to relocate to metropolitan areas
- Difficulties getting rural services accredited for training, as the benchmarks that are used for eligibility are based on metropolitan norms that are not appropriate for rural practice
- Lack of recognition that there are specific competencies and issues related to rurality, that are not provided by metropolitan training

These problems lead to a crisis of sustainability for almost all specialists who work in rural palliative medicine, and for the services in which they work. What has emerged is that rural services face significant challenges at every stage of their development. The RRIPM scoping review confirms that the key to surviving and thriving for rural services is to be able to train the next generation of rural palliative medicine specialists and create a pipeline of trainees – both specialist and generalist - to meet the future needs of their service and community. This is the existential challenge for rural palliative care services, and it has led to the establishment of the RRIPM project.

Palliative care is not a high-tech specialty. There is no reason why training and excellent care cannot occur outside the metropolitan centres, and those who currently live and work rurally understand this well. They are also eager to ensure that their colleagues and potential trainees understand this too. With the development of RRIPM, which will grow out of the experiences and advice of those clinicians who can see a way forward, the opportunity exists to create a system which nurtures trainees and palliative medicine specialists to live, work and train in rural settings, and enables them to continue to provide care at the highest standard to their communities. The capacity created by rurally based specialist services has flow-on effects that are very precious for rural communities - training and support for generalists, catalysing the development of multidisciplinary teams that can sustainably provide care in local communities, and the ability for excellent care to be provided where it is most wanted – close to home.

Dr Christine Sanderson
Clinical Lead, RRIPM

1. Introduction

The Rural and Remote Institute of Palliative Medicine [RRIPM] Project aims to improve access to quality palliative medical care for people living in rural Australia. This aim will be realised over time by supporting the rural palliative medicine workforce and creating an attractive rural training pathway.

Objectives

The RRIPM Project will develop and implement a Palliative Medicine training network in rural and remote communities that:

- ensures a skilled rural palliative specialist workforce for the future
- provides opportunities, through shared and networked pathways, for trainees to complete most of their training in rural settings
- identifies opportunities, and supports pathways for, Aboriginal and Torres Strait Islander trainees
- provides ongoing career support to specialists completing training within the RRIPM network.

Once fully established, RRIPM will offer an integrated Rural and Remote Training experience:

- designed by rural doctors for rural doctors.
- based on RACP competency-based training curriculum
- offering a full range of high-quality training experiences
- ensuring a positive and supported rural and remote training experience

The initial project phase is funded through a Flexible Approach to Training in Expanded Settings (FATES) grant from the Department of Health and Aged Care. This grant is being administered by the Royal Australasian College of Physicians (RACP).

Project Design

To achieve the objectives outlined above, a two-phase approach has been adopted.

a. **Scoping Phase**
   During the scoping phase, a rapid assessment of palliative medicine training across the country is mapping barriers to and opportunities for rural palliative medicine training.
   The scoping phase commenced in July 2023 and is expected to be complete by March 2024.

b. **Implementation phase**
   During the implementation phase, rural networks of training ready providers will be developed and supported through an evolving RRIPM process.
   The implementation phase will commence after approval of recommendations, and once future funding has been secured.

Timeline

The project timeline sets an ambitious schedule for progress.

RRIPM project timeline

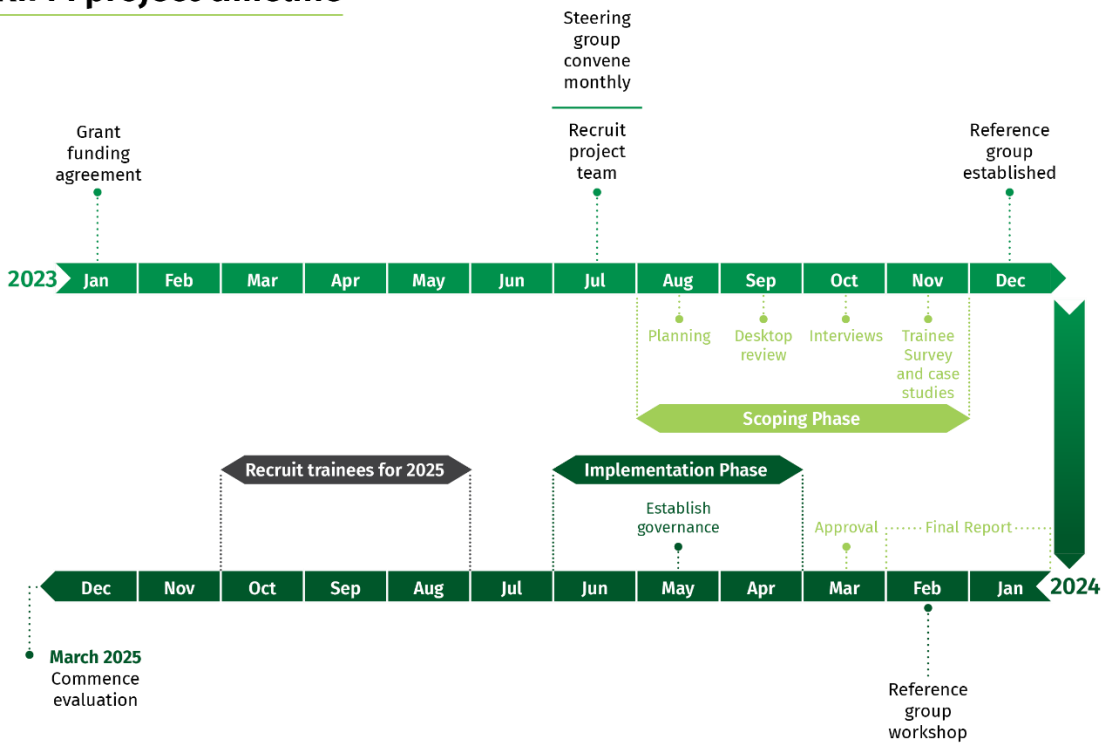

Figure 1: RRIPM project timeline, 2023

Scoping Phase Methodology

To understand the current palliative medicine Advanced Training landscape in rural Australia activities undertaken during the scoping phase have been guided by regular input from a project steering group [Appendix 1], and design input from key sector stakeholders, reference group and expert discussions.

Activities have included:

- Completion of a desktop policy review to position the RRIPM project within the broader National health and palliative care policy context.
- Virtual and / or in-person semi structured interviews conducted with 58 key informants, including 43 FAChPM participants from palliative care services across all jurisdictions of Australia; and an additional 15 stakeholders representing peak bodies, workforce agencies and jurisdiction leads.
- An online survey completed by individuals currently undertaking palliative medicine Advanced Training [n= 75 respondents / 35% response rate]
- Following on from the investigations of the scoping project, a series of deep dive case studies to illustrate the reality of rural training pathways for trainees and supervisors will be published.

2. Background

Around 7 million Australians (28% of the population) live in rural or remote areas. (AIHW, 2023) However, there are significant disparities in the kind of palliative care that is available in different geographic locations in Australia.

Specialist palliative care is delivered by multi-disciplinary teams, working across a range of health care and community settings. The core components of a specialist palliative care service include in-patient care, consult services, community care, after hours support, respite, psychosocial support, and bereavement care. Increasingly, subspecialty palliative care is also provided, addressing specific populations and disease categories. As described in the PCA Palliative Care Service Development Guidelines (2018), level 3 specialist palliative care, including all the core components, is concentrated in major metropolitan centres. Training in palliative medicine is also overwhelmingly metropolitan-based. In the PCA model, as we get further from the metropolitan centres the assumption is that there will not be multidisciplinary palliative care teams or specialist palliative care beds, and palliative care will instead be provided by generalists with support and advice from metropolitan or regional specialist colleagues, rather than as a local, integrated, team-based service whose primary objective is to provide excellent palliative care. The PCA model of service development is population-based. This means that the services intended for people with complex needs are almost exclusively based in metropolitan and inner regional areas. Yet complexity of care needs is not restricted to these settings.

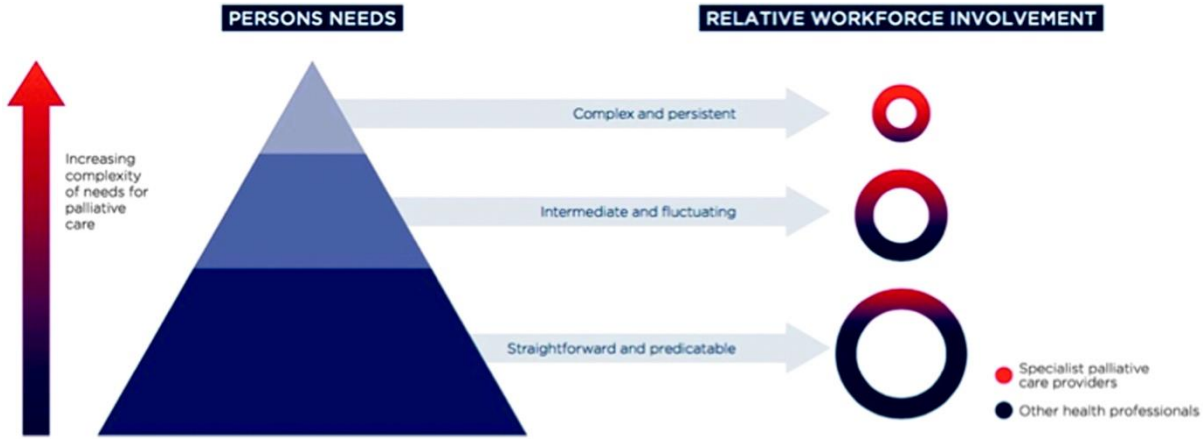

Figure 2 Alignment of the need for palliative care against workforce capability. Source: (PCA, 2018)

The reality on the ground is in fact somewhat different to the three-level service model previously proposed by PCA. In practice there are a range of specialist services and rural models evolving in response to the needs and demands of people in those communities. For example, many rural communities fundraise, lobby for, and fiercely support the development of local hospice units, and alongside clinicians in those rural communities they work hard to establish palliative care teams, secure funding, and develop an appropriate approach to their local challenges in an environment of scarce resources. The aim of these communities is often to provide many of the services that are

identified in the PCA Service Development Guidelines as part of a level 2 or 3 metropolitan specialist palliative care service.

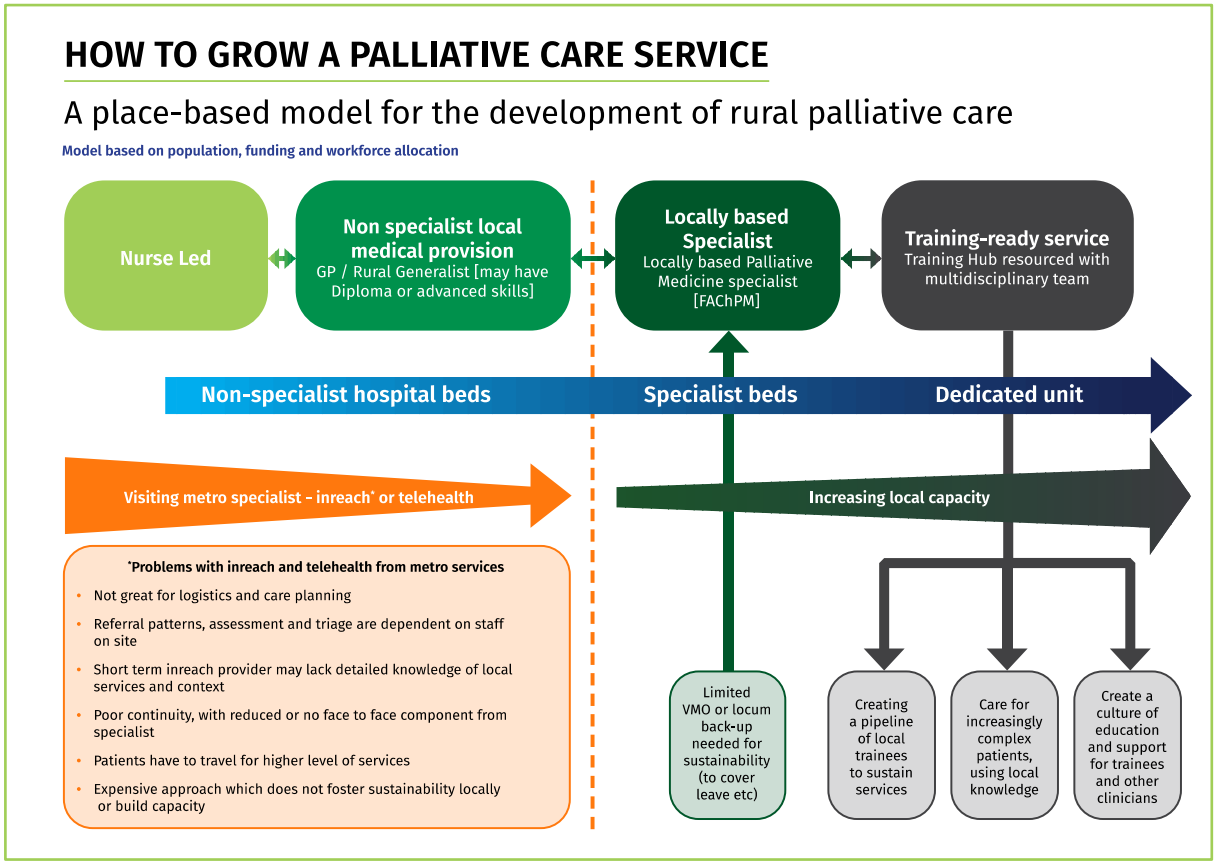

Figure 3: A place – based model for the development of rural palliative care

The place-based model for the development of rural palliative care services (figure 3) illustrates the process by which rural services tend to evolve. The model has been developed as part of the RRIPM project to help describe a continuum of service development. It has been preliminarily validated with rural services as part of the consultation. It shows how having a rurally based specialist functions to develop the capacity to train both specialists and generalists, as well as to provide higher levels of care locally and catalyse the evolution of a dedicated palliative care team. The increased capacity that comes at that point allows that service to then support other rural services within their region, and reduces dependence on expensive in reach, locum, and retrieval services.

Snapshot of the Palliative Medicine Specialist workforce

The role of the palliative medicine specialist within the multidisciplinary team is critical to the sustainability of an effective palliative care service. According to the Australian Institute of Health and Welfare, (AIHW), current palliative medicine workforce across Australia has seen an overall increase of 30% in employed palliative medicine specialist physicians during the period 2016-2020. This correlates with an overall increase in the available full-time equivalent [FTE] workforce of 21.9%. (AIHW, 2021-2022) This growth does not keep pace with population need.

Workforce Distribution

The palliative medicine specialist workforce is concentrated in major cities. Workforce numbers are not static, so the following data presents a snapshot at a point in time and can be considered indicative. As shown in Table 2 below, of the total 560 palliative medicine specialists, 472 practiced in major cities comprising 84.3% of the palliative medicine workforce. The numbers and percentages dropped significantly in inner regional, and outer regional centres to a single specialist working in a permanent position in remote Australia.

Australian Statistical Geography Standard	Equivalent Modified Monash Model	# Palliative Medicine Fellows	Percentage of Fellows by rurality
Major Cities	MM1	472	84.3
Inner Regional	MM2	71	12.7
Outer Regional	MM3-5	16	2.8
Remote	MM6-7	1	0.2
Total		560	100%

Table 2: Distribution of Palliative Medicine Fellows by Australian Statistical Geography Standard and MMM Source: (RACP, 2023)

Palliative Medicine Physicians per 100,000 population

PCA service development guidelines [2018] propose medical staffing levels required for specialist palliative care services per 100,000 population. The physician workforce required to deliver care in community based, consultation and palliative care designated beds range from 1.5 to 2 FTE per 100,000 population (PCA, 2018)

Despite the reported overall increase in palliative medicine physician numbers for the period 2016-2020, the PCA recommended FTE for palliative medicine physicians remains unmet. Figure 4 below highlights in metropolitan areas the reported FTE per 100,000 population is 1.2, and in outer regional / rural locations it is 0.5 FTE per 100,000 population, or fewer with this figure decreasing to almost non-existent in most remote locations.

This demonstrates not only a significant palliative medicine workforce shortage in general, but also a critical rural – metropolitan mal-distribution.

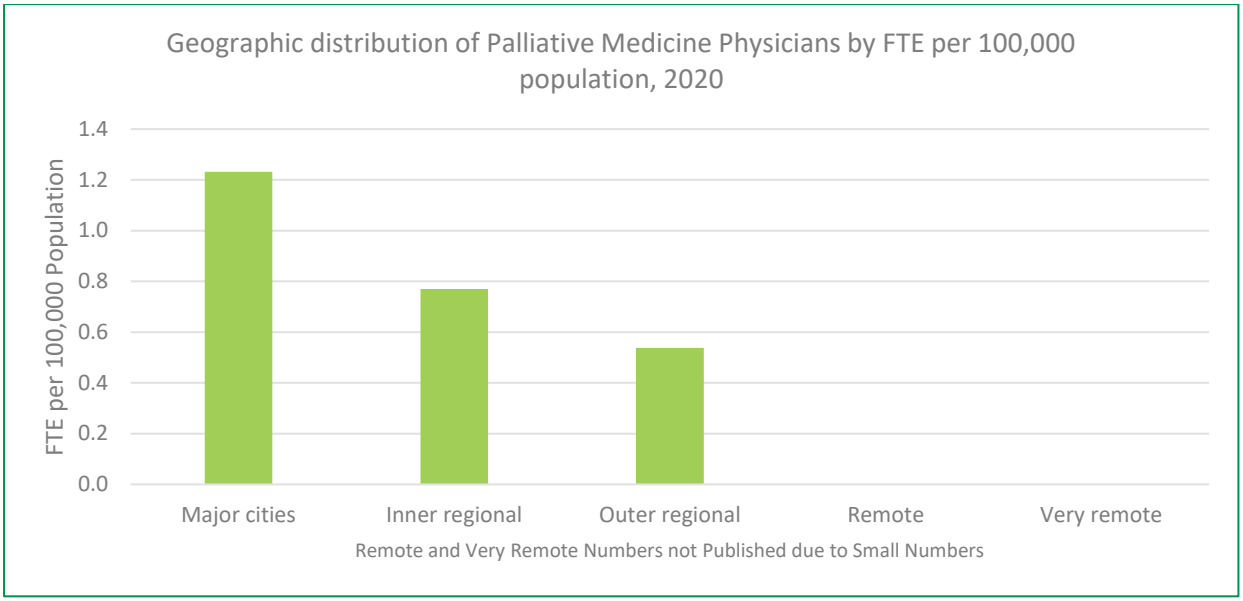

Figure 4: Geographic Distribution of Palliative Medicine Physicians by FTE per 100,000; Source: (AIHW, 2021-2022)

Overall, the palliative medicine workforce remains well below a level sufficient to deliver quality palliative care to meet the growing needs of the cohort of ageing and ailing population in years to come.

Demographic Profile

According to AIHW data, [Figure 5] the age profile of employed palliative medicine physicians shows the largest growth in uptake of palliative medicine as a specialty occurred in the 35-44 age group with a 65% increase across the reporting period 2016-2020. (AIHW, 2021-2022)

Between 2013 and 2021 the number of Aboriginal and Torres Strait Islander registered medical practitioners has more than doubled from 234 to 563 people however data is not available to know the number of individuals who opt to undertake advanced training in palliative medicine. (National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021–2031)

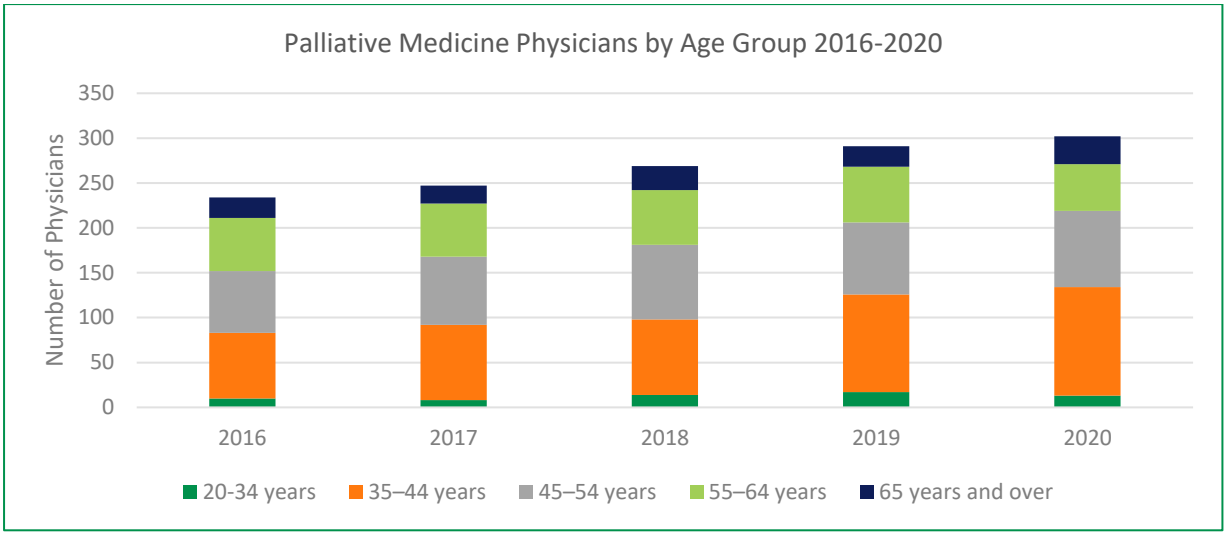

Figure 5: Palliative Medicine Physicians by age group, 2016-2020. (AIHW, 2021-2022)

Palliative Medicine Advanced Trainees

Table 3 below shows the total number of palliative medicine advanced trainees in Australia [as at November 2023] and the rural distribution of these trainees. Like the distribution of palliative medicine specialists, advanced trainees are concentrated in major cities with fewer trainees in regional and remote locations.

Australian Statistical Geography Standard	Equivalent Modified Monash Model	# Palliative Medicine Advanced Trainee	Percentage of trainees by rurality
Major Cities	MM1	182	83.8
Inner Regional	MM2	20	9.2
Outer Regional	MM3-5	13	6.0
Remote	MM6-7	2	0.9
Total		**217**	**100%**

Table 3: Distribution by Advance Trainees in Palliative Medicine by Australian Statistical Geography Standard and MMM. Source: (RACP, 2023)

Clinical Foundation in Palliative Medicine

Table 4 below shows the number of Clinical Foundation [previously Clinical Diploma] trainees in Australia [as at November 2023] and the rural distribution of these trainees following a similar distribution to fellows and advanced trainees.

Australian Statistical Geography Standard	Equivalent Modified Monash Model	# Palliative Medicine Clinical Foundation	Percentage by rurality
Major Cities	MM1	168	75
Inner Regional	MM2	36	16
Outer Regional	MM3-5	18	8
Remote	MM6-7	1	0.2
Total		**223**	**100%**

Table 4: Distribution by Clinical Foundation trainees by Australian Statistical Geography Standard and MMM. Source: (RACP, 2023)

The future rural workforce – from graduation to specialisation

In 2022, upon graduation from medical school, approximately one in six medical graduates from non-rural settings intended to pursue a career outside capital or major urban centres. By contrast, **one in every two graduates from a rural background intended to progress their career outside a capital city or major urban area.** [Figure 6] (Medical School Outcome Database, 2023)

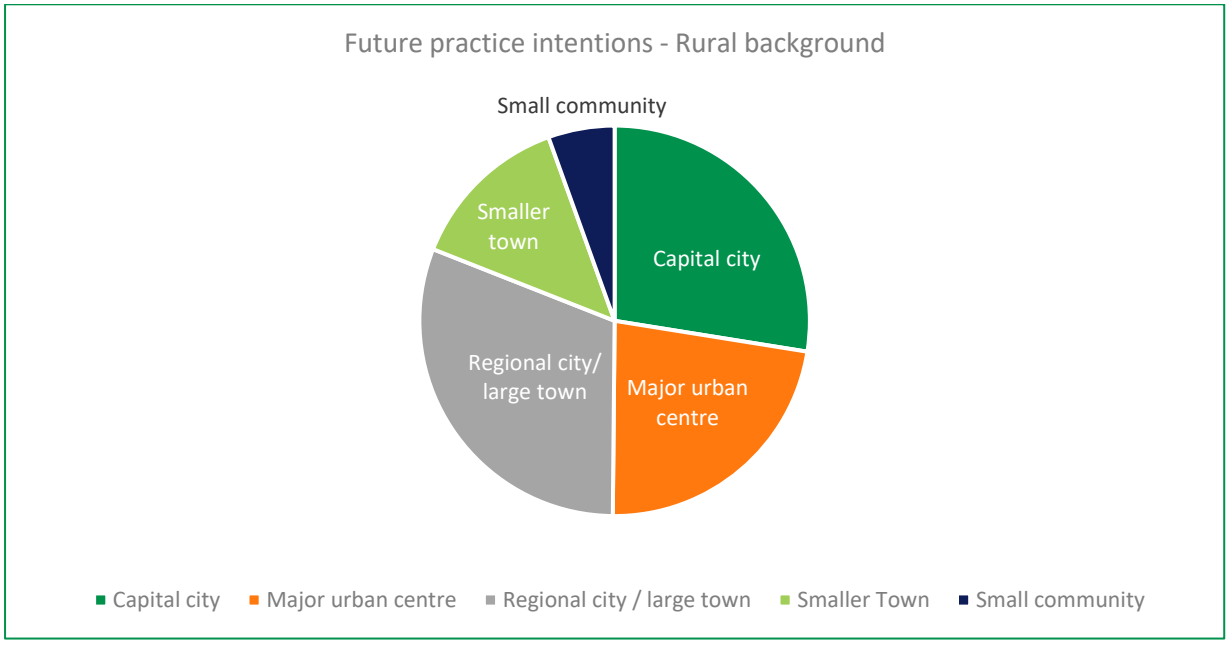

Figure 6: Preferred location for future practice medical graduates from a rural background. Source: *National Data Report 2023* Medical Deans Australia and New Zealand website, 2023, accessed 21 November 2023.

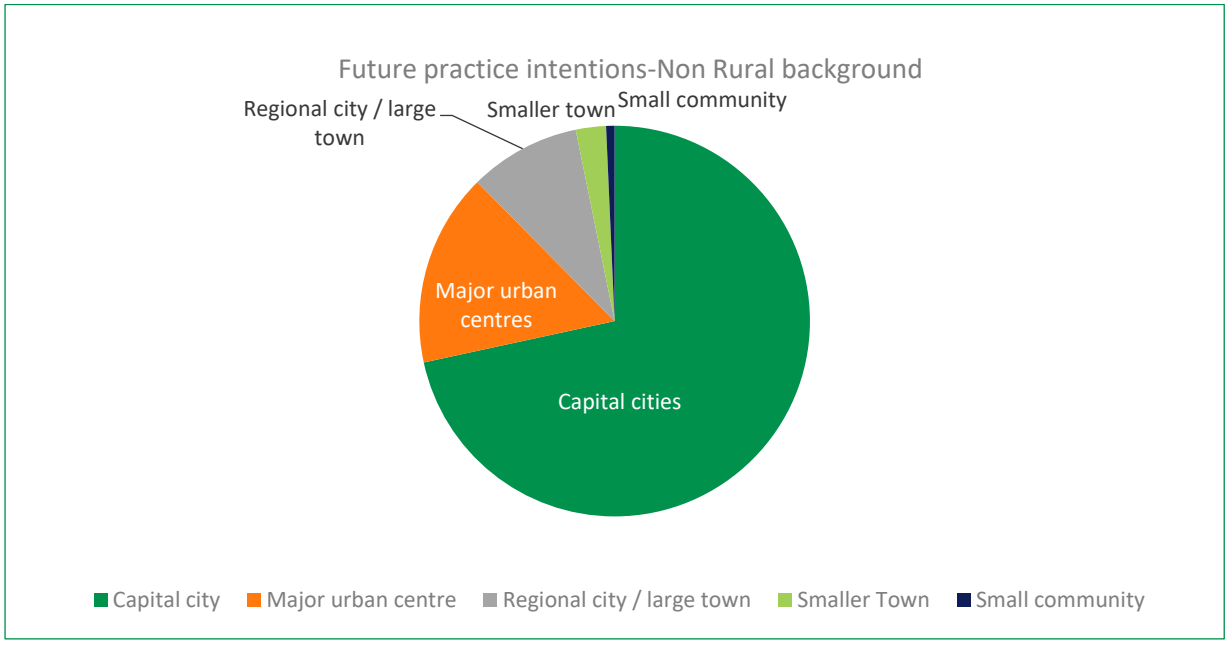

Figure 7: Preferred location for future practice students from a non-rural background. Source: *National Data Report 2023* Medical Deans Australia and New Zealand website, 2023, accessed 21 November 2023.

It is widely acknowledged across many specialties that the availability of attractive rural career pathways to recruit and support rurally focused medical graduates, to undertake advanced training pathways of their choice, is critical to building workforce capacity for sustainable services in rural Australia, whilst metro-centric training leads to fewer rural specialists. When considering the potential recruits for rural training, it is important to also recognise that there are two groups of trainees to consider, whose needs and circumstances are very different:

- Metropolitan trainees, who may be encouraged to consider working rurally in the future
- Clinicians who are already based in a rural setting (either trainees, generalists, or specialists in other discipline) who have an interest in training in palliative medicine, and for whom the barriers to training are very different.

The training pipeline – a key concept for rural workforce planning

The concept of a "training pipeline" is essential for future workforce planning. The proposed elements of the concept for rural palliative medicine are that:

- The capacity to locally train clinicians to provide palliative care is critical
- Rurally based specialists are needed to train both generalists and specialists in palliative medicine
- Rural communities need a balanced mix of generalists and specialists to be involved in the ongoing provision of palliative care, and to ensure the sustainability of palliative care services
- Training opportunities that are created should be able to support both specialist and generalist trainees
- Generalists who have undertaken some palliative care training (Clinical Foundation or AST in palliative medicine) may wish to continue to specialist training at some point, and that should be able to be facilitated
- Training programs (generalist and specialist) should ideally be inter-operable, so that mutual accreditation and recognition of prior learning are supported.

Trainees in palliative medicine in Alice Springs – Dr Aaron Bagnato (physician trainee) and Dr Hayley Cameron (rural generalist trainee) Credit: C. Sanderson

3. Strategic Policy Alignment

At the national policy level, strategy documents and frameworks outline important workforce, structural and funding approaches to palliative care. The intended outcomes of the RRIPM project have been reviewed in the context of how they align with the following guiding documents:

- National Palliative Care Strategy [NPCS], 2018
- National Medical Workforce Strategy 2021-2031
- Ngayubah Gadan [Coming Together] 2023
- Aboriginal and Torres Strait Islander Health Workforce Strategy, 2021-2031
- Australian Indigenous Doctors' Association- Growing the number of Aboriginal and Torres Strait Islander medical specialists
- RACP Regional, Rural and Remote Physician Strategy, 2023
- Palliative Care Service Development Guidelines 2028
- KPMG Final Report. Investing to save 2020
- Specialist Training Program [STP] Operational Framework 2022-2025

This section briefly reviews key aspects of national strategies and frameworks, highlighting RRIPM alignment within the policy context.

National Palliative Care Strategy [NPCS], 2018

This strategy described a vision that 'people affected by life-limiting illnesses get the care they need to live well'. It determines that palliative care needs to be flexible and responsive to ensure that care is accessible, respectful, culturally safe, and appropriate according to need. This NPCS outlines the importance of investment at national, state and territory levels, required to ensure that the systems and people are available to provide quality palliative care where and when it is needed. Within this strategy, specialist palliative care services are acknowledged as playing an important role in meeting complex needs. **The role of palliative care specialists is important not only in the delivery of care, but also in the support and building capacity of other providers in palliative care. P20** (Department of Health, 2018)

National Medical Workforce Strategy 2021-2031

In the preface to the National Medical Workforce Strategy [NMWS] 2021-2031, Brendan Murphy Secretary Commonwealth Department of Health, stated:

> *'…The medical workforce has a profound impact on the quality, accessibility, effectiveness, and sustainability of the health system. However, inequality of access to health services remains a key issue for Australian communities. To achieve maximum benefit to the community,* ***the medical workforce must be geographically well distributed*** *and have the appropriate mix of medical specialties in each location. Currently this optimal distribution*

and service mix is not consistently achieved across Australia, resulting in service gaps and inefficiencies, and potentially impacting on the quality of patient care and the working life of Australia's doctors…P4' (Department of Health, 2021)

This statement succinctly summarised the issues faced by people seeking care, including specialist palliative care, in many rural communities. It reinforces the logic underpinning the RRIPM project which aims to address the geographic maldistribution of specialist palliative medical specialists in rural Australia.

Key priority actions identified in the NMWS 2021-2023 specifically align with the aspirations of the RRIPM project. The first priority is the need to improve collaboration.

To ensure the medical workforce continues to meet the needs of the broader Australian population, stronger collaborative planning, information sharing, and action is proposed amongst stakeholders within the medical workforce sector.

As illustrated in Figure 8 there is significant complexity in the Australian workforce planning structure. Much needed system change will not be achieved without partnership and collaboration.

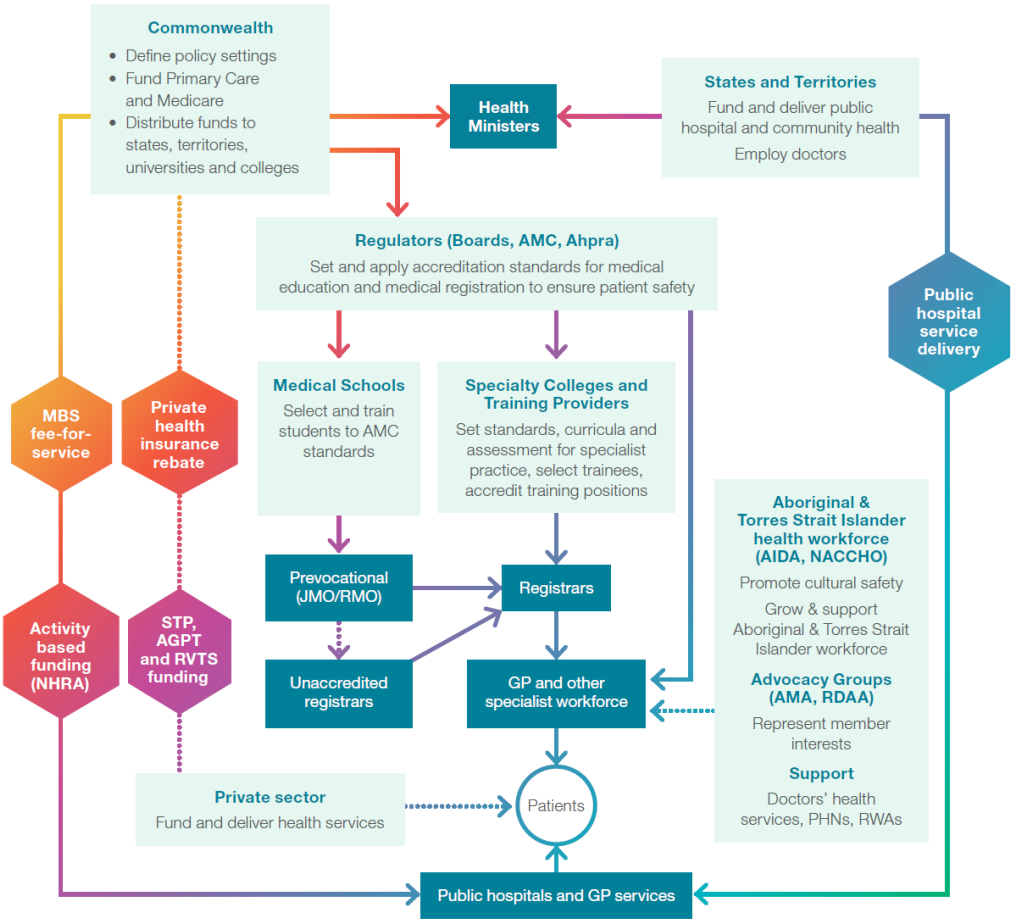

Figure 8: Australian workforce planning structure. Source: National Medical Workforce Strategy NMWS 2021-2023

Strong cross sectoral engagement and input has been sought from regulators, Colleges, jurisdictional health services and the broader palliative care and rural health diaspora, to position effective change recommendations and actions. The RRIPM reference group is key to progressing these important discussions.

The strategy identifies a priority need to reform Training Pathways. The phenomena of investment in metropolitan tertiary centres providing high-quality metropolitan services but creating metro-centric training systems – has ultimately led to disproportionate workforce distribution affecting rural locations across the nation and requires refocusing.

Understood as a validation of the RRIPM aim, the NMWS states that '**Specialties that can operate to their full scope of practice outside metropolitan centres will be expected to provide training in rural areas'.** P12

Further, 'accreditation and supervision standards will be adjusted to recognise excellence in rural training and to facilitate longer and more placements in rural areas. This may also occur through innovative supervision approaches, networked models, and relationships with tertiary hospitals in cities.' P12

Recommendations arising from RRIPM consultations provide clear direction to inform required adjustments.

Finally, *a flexible and responsive medical workforce* - will require system changes to build opportunities for lateral movement across sites and through innovative employment models and practices, including portability and uniformity of benefits and employment arrangements. Achieving this type of change will require flexibility and engagement at the national, state, and local level. P13

Ngayubah Gadan [Coming Together] Consensus Statement: Rural and Remote Multidisciplinary Health Teams 2023

This consensus statement outlines the vital role multidisciplinary teams play in high-quality health care delivery in rural and remote Australia. It outlines key elements and enablers required to establish and support high functioning sustainable rural and remote multidisciplinary teams noting '**patient care, and specifically rural and remote patient care, is most effective when managed within place-based, multidisciplinary models of care with teams working together.'**

Aboriginal and Torres Strait Islander Health Workforce Strategy 2021-2031

This framework sets out strategies to bolster recruitment and retention of Aboriginal and Torres Strait Islander health professionals, provide culturally safe workplaces, and ensure data collection and monitoring capability is sufficient for workforce planning and monitoring of cultural safety targets. (National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021–2031). RRIPM has the opportunity and the intent to offer all trainees an exceptional workplace experience in culturally rich environments. It is hoped Aboriginal and Torres

Strait Islander medical graduates will have opportunity to follow a rural palliative medicine advanced training pathway.

Australian Indigenous Doctors' Association- Growing the number of Aboriginal and Torres Strait Islander medical specialists,2020

This self-assessment document outlines minimum standards and best practice standards by which specialist medical Colleges will be measured aimed at attracting, recruiting, and retaining Aboriginal and Torres Strait Islander trainees. In a health system where racism still occurs, it is critical that specialist Colleges understand, practice, and promote cultural safety, for trainees and the Aboriginal Torres Strait Islander population accessing care.

RACP Regional, Rural and Remote Physician Strategy

This RACP strategy document released in June 2023 was informed in part by the Australian National Medical Workforce Strategy 2021–2031. The RACP working group explored important topics such as barriers to training, supervision and accreditation issues, models of care, changing perceptions of working as a physician in regional, rural, and remote areas. The ensuing principles and recommendations build a positive foundation upon which RRIPM can work to address change.

The five recommendations endeavour 'to provide a roadmap for the RACP to steer away from the inequitable status quo and reverse what is perceived as an outdated and culturally traditional metro-centric way of physician training to a more inclusive and well-rounded way of training and providing future physicians to all communities.' P15 (RACP, 2023)

RRIPM is well positioned to be the test case working with the College to implement this change, and to expedite the shift to network accreditation across participating sites.

Palliative Care Service Development Guidelines 2018

The purpose of these guidelines is to communicate the expectation of Palliative Care Australia for the range of palliative care services that should be available to people living with a life-limiting illness, their families, and carers; and the workforce and system capabilities required to deliver an effective network of palliative care services using a population-based approach to service planning.

The guidelines acknowledge the range of providers working in multi-disciplinary teams within a palliative care service, and the continuum of care provided. The need to **align the complexity of a patient's care needs with workforce capability** to address these needs is well described. P12

Also described is the need to support health professionals providing palliative care. Palliative care is a demanding area of work with significant psychological stressors and challenges. Appropriate resourcing and support structures are required to ensure a resilient workforce. The RRIPM project is well aligned with the principles underpinning the PCA service development guidelines.

Investing to save: The economics of increased investment in palliative care in Australia, 2020

This report, while not a policy document, 'presents the economic case for increased investment in palliative care. It highlights opportunities for governments to generate significant returns on their investment in palliative care, focussing on targeted practical interventions where the evidence about what works is strong'. P9

From a financial perspective, the return on investment comes from reducing costly end of life emergency department visits and transport, hospitalisation, and intensive care admissions. The evidence is strong that improving access to care at home through well-resourced community based palliative care services is very effective. Additional arguments can be made in the setting of rural and remote palliative care services, which have the potential to reduce inappropriate transfers to higher levels of care and can therefore influence the expenditure on retrievals and service utilisation, as well as the costs borne by patients and families when patients are transferred to regional or metropolitan settings at the time when they are approaching the end of life.

The financial imperative is underpinned by mortality projections that demonstrate '**the need for palliative care is growing faster than both the population and the total deaths.'** P32

Specialist Training Program [STP] Operational Framework 2022-2025

'The Specialist Training Program (STP) seeks to extend vocational training for specialist registrars (trainees) into settings outside traditional metropolitan teaching hospitals, including regional, rural, remote, and private facilities. The program aims to improve the quality of the future specialist workforce by providing non-GP specialty trainees with exposure to a broader range of healthcare settings. STP also aims to have a positive influence on future medical workforce distribution.' P2 (DOHAC, 2022)

4. RACP Palliative Medicine Fellowship program

According to the RACP specialty overview, 'palliative medicine specialists provide holistic supportive care for people with life limiting illness due to non-malignant disease or cancer. The specialty employs a person and family centred model of care to ensure that family and carers also receive practical and emotional support. Palliative medicine specialists contribute to building capacity in non-specialist healthcare teams, families, and communities to care for people with life-limiting illness and work to normalise the experience of dying and bereavement as part of life. This high-quality care is enhanced by research, quality improvement, policy development, and advocacy.'

At the time of writing this report the advanced training curricula standards are under active review. Pending the outcome of the review, changes may be required across the whole system to align accreditation and training terms in keeping with the revised curriculum. The following information is based on current curricula which is anticipated to move to a competency-based model in early 2024.

There are two pathways for entry to RACP Advanced Training in palliative medicine.

- RACP Fellowship – after completion of Basic Physician Training
- Chapter Fellowship – with Fellowship from another prescribed College such as the Royal Australian College of General Practitioners

To be recognised as a Palliative Medicine Specialist, doctors must complete three years of supervised training in an Adult [or Paediatric] setting and undergo prescribed work-based assessments in accredited training sites.

Once a trainee has completed all requirements of the advanced specialist training, the candidacy will be reviewed by the RACP Training Committee in Palliative Medicine [TCPM] and a recommendation made for admission. The College will invite successful candidates to apply for Fellowship of the RACP and the Australasian Chapter of Palliative Medicine (RACP Basic Trainees pathway) or Fellowship of the Australasian Chapter of Palliative Medicine (post- Fellowship pathway).

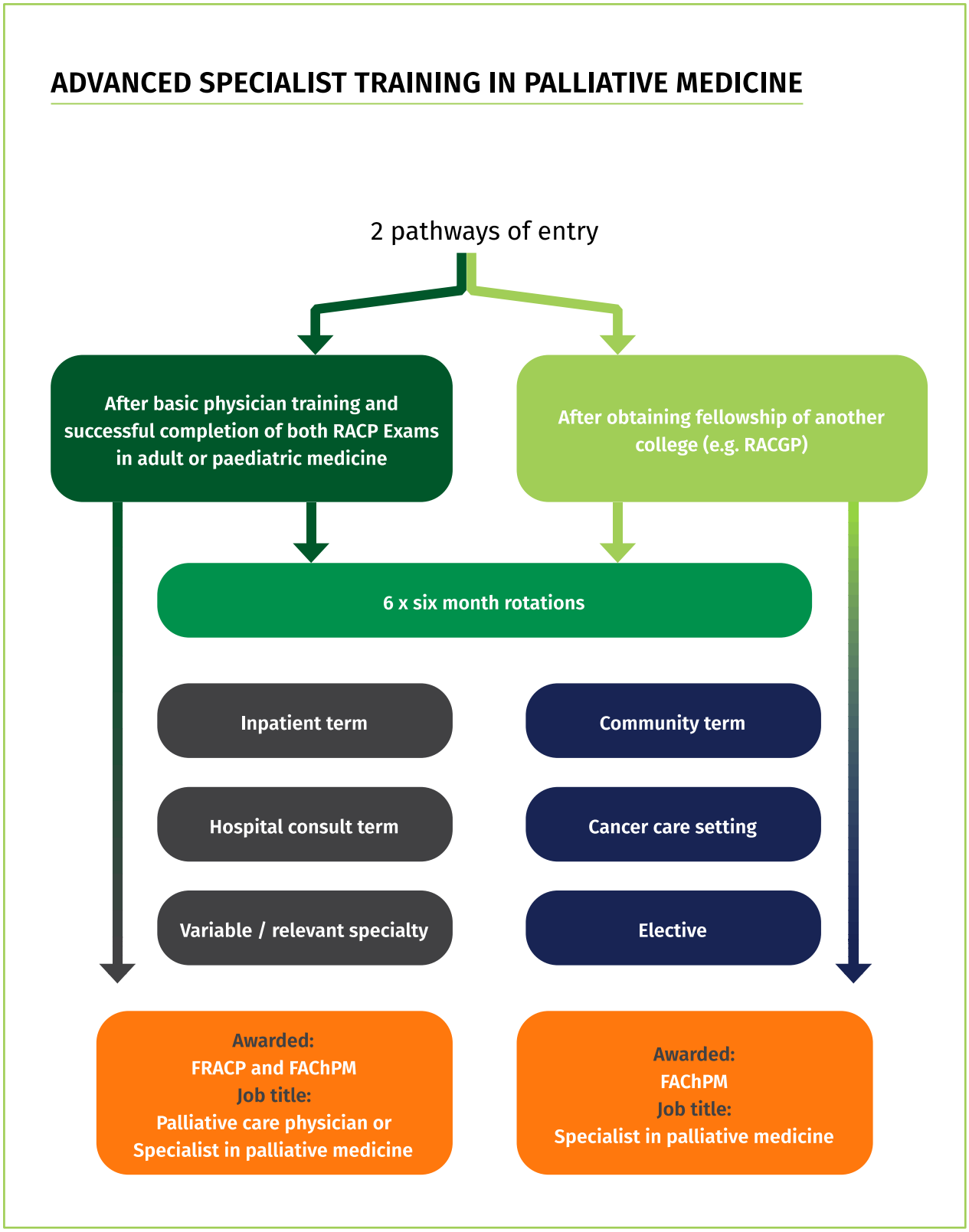

Figure 9: Training pathways for advance specialist training in palliative medicine. Source: https://www.vpmtp.org/training/advanced-specialist-training accessed 21 Nov 2023

The training pathway currently consists of work-based learning and assessment. After 36 months of certified training time a trainee will have completed:

- 24 months of core training, including
- 6 months of inpatient unit/hospice
- 6 months of community setting
- 6 months of teaching hospital/consultation
- 6 months of cancer care setting
- 12 months of non-core training including
- 6 months of palliative medicine variable or related specialty
- 6 months of elective training
- 1 x Advanced Training Research Project
- 1 x Case Study
- Australian Aboriginal, Torres Strait Islander and Māori Cultural Competence and Cultural Safety online course (trainees who commenced in 2023 onwards)
- Communication Skills Workshop (recommended)
- RACP Online Learning: Pain Management modules

Clinical Foundation in Palliative Medicine (6 months)

The RACP Clinical Foundation in Palliative Medicine program, [until recently known as the Clinical Diploma in Palliative Medicine] provides general practitioners or any other interested medical practitioners a structured program of clinical experience in palliative medicine. It aims to expand their expertise to handle the palliative care needs of patients in their practice. The Clinical Foundation in Palliative Medicine requires 6 months of full-time equivalent (FTE) training undertaken in an accredited setting with supervision from a Fellow of the RACP or AChPM, actively practising in palliative medicine. Completion of this course does not confer eligibility for specialist recognition in palliative care medicine.

Other Advanced Skills Training (12 months)

Another component of the rural medical workforce relevant to palliative care practice is the rural generalist (RG). Rural Generalists are GPs who have trained through either of the two Colleges of general practice (RACGP or ACRRM), and who have completed additional ‘advanced’ or ‘extended’ skills training (AST) in a particular area of relevance to their rural communities. Currently, there is a submission before the national regulatory bodies to recognise rural generalism as a separate specialty within general practice.

The College programs differ slightly in their requirements, which are detailed below. Despite the differences, additional AST training for RGs with either College encompasses a year full-time equivalent

in their chosen specific specialty. Historically, the initial RG training programs focused on 'procedural' specialties and skills including emergency medicine, surgery, anaesthetics, and obstetrics & gynaecology. In more recent years, 'non-procedural' advanced training has been developed in specialties under-represented in rural communities including paediatrics, psychiatry, and palliative medicine. The training must occur within a recognised specialist service setting, and most commonly occurs in the services providing care to rural populations. Completion of the AST does not confer eligibility for specialist recognition in palliative care medicine.

Royal Australian College of General Practitioners [RACGP]

The Fellowship in Advanced Rural General Practice (FARGP) is a qualification awarded by The Royal Australian College of General Practitioners (RACGP) in addition to the vocational Fellowship (FRACGP). Completion of a minimum 12 months of Additional Rural Skills Training (ARST) in an accredited training post is an essential component of training towards FARGP. This additional palliative medicine training is designed to augment core general practice training by providing an opportunity for rural general practitioners (GPs) to develop additional skills and expertise in a particular area and enhance their capability to provide secondary-level care to their community with critical knowledge, skills and attitudes to effectively deliver end-of-life care in rural and remote environments, where specialist support is often limited. (RACGP, 2021) Supervision is provided by a rural GP supervisor/mentor, a medical educator, and palliative medicine physician who is a Fellow of the Royal Australasian College of Physicians (RACP) or a Fellow of the RACP's Chapter of Palliative Medicine.

Australian College Rural and Remote Medicine [ACRRM]

Fellows of ACRRM receive specialist registration as a general practitioner with the Medical Board of Australia and can practise in any location throughout Australia. ACRRM's standards and training also prepare doctors to be rural generalists.

> *'A rural generalist is a general practitioner who has specific expertise in providing medical care for rural and remote communities. A rural generalist understands and responds to the diverse needs of Aboriginal, Torres Strait Islander and other rural communities; this includes applying a population approach, providing safe primary, secondary and emergency care as required and providing specialised medical care in at least one additional discipline.'p4 (ACRRM, 2023)*

Palliative Care is recognised as one of the additional areas of specialised medicine that a rural generalist may undertake. Advanced specialised training in palliative care requires a minimum of 12 months full time and must be undertaken in teaching posts accredited by ACRRM.

It is suggested an ideal teaching program would include six months in a RACP accredited post however this is not mandated. Supervision can be provided by FAChPM, or a rural generalist with AST in palliative care.

There is strong anecdotal evidence that a proportion of RG registrars who complete an AST will then pursue further training to obtain their full specialist recognition in their chosen specialty. This is particularly noted with anaesthetics, and obstetrics & gynaecology ASTs; but the trend is also emerging in the more recently established ASTs of palliative care, paediatrics, and psychiatry. Several rural specialist palliative care services in NSW report that around 30 - 50% of registrars who initially complete an AST in palliative medicine then proceed to Advanced Training to obtain their FAChPM.

Interface between Specialist and Rural Generalist AST

The training of rural generalists in palliative medicine will not replace, or diminish the need for, palliative medicine specialists to work in rural centres. The professional relationships between the two groups will continue to develop synergistically over time, with networks of rural generalists in small rural and remote communities supporting and supported by palliative medicine specialists and palliative care services based in larger rural centres who will provide broad outreach services. This enables palliative medicine specialists to provide support and higher-level complex management across a broader geographical area with a level of confidence in the skills of their rural generalist colleagues.

At present there is no co-ordination between the three Colleges who, between them, provide specialist and rural generalist palliative care training. There is no mutual agreement about accreditation of training sites or rotations, no consideration of coordinating recruitment, nor any clear acknowledgement from the Colleges involved that completion of rural generalist palliative care training should be or could be a valid step in a rural specialist training pathway for those who wish to pursue it, and that recognition of prior learning is appropriate in that situation.

5. Recruitment

How are Advanced Trainees recruited?

There is significant variation in recruitment practices, and core term placement opportunities across, and within jurisdictions. In jurisdictions with a central intake, candidates are interviewed and ranked with placements allocated according to ranking. Candidate preference of training location is generally considered in the placement process.

In some jurisdictions, trainees have no guarantee of future placement or ongoing employment, and application and negotiation are required for each term. Given the rotation and supervision requirements of the curriculum, rural trainees are currently unable to complete training without the need to relocate during their training, sometimes multiple times.

The following section summarises the approach to recruitment by jurisdiction.

Australian Capital Territory [ACT]

Recruitment to palliative medicine advanced training in the ACT is currently undergoing a transition since the acquisition of Calvary Healthcare facilities by the ACT government, creating a single palliative care service. Candidates who wish to undertake advanced training apply centrally to the Canberra Health Services advertisement and are allocated to placements within the ACT accredited sites, across which, trainees are *currently* able to complete all of their training. This is fluid, and dependant on funding provisions and available positions.

New South Wales [NSW]

Palliative medicine specialist services in NSW are best described as comprehensive metropolitan and regional services partially networked through the Sydney Institute of Palliative Medicine [SIPM]. Recruitment for advanced trainee positions is theoretically centralised by NSW Health with an annual JMO recruitment campaign. Palliative medicine advanced trainee placements are facilitated by the SIPM network. In practice, the centralised recruitment process predominately covers metropolitan Sydney, Wollongong, and the Central Coast / Newcastle conurbation. Whilst the recruitment process is available to rural and regional services, it is not commonly used. Regional services offering specialist training posts report that they have more success in recruiting directly to their own vacancies, than through the SIPM centralised process.

Northern Territory

Palliative medicine specialist services in Northern Territory [NT] are best described as a hybrid with a metropolitan outreach service [Darwin] covering the northern region, and a regionally based Alice Springs service providing outreach across Central Australia and over the border into South Australian and Western Australian Aboriginal-controlled lands. Recruitment for advanced trainee positions in NT occurs annually by application to the individual service recruiting into a vacancy. The two services are not formally networked.

Queensland

Palliative medicine specialist services in Queensland can be understood as segregated into metropolitan and non-metropolitan. Recruitment for Palliative Medicine Advanced Training and the Clinical Foundation of Palliative Medicine is centrally coordinated by the Queensland Palliative Medicine Training Program.

This statewide approach to recruitment and rotation, aims to ensure Advanced trainees have coordinated access to appropriate terms within the Palliative Medicine Training Pathway. This offers accredited placements in predominately metropolitan and large regional locations across the state.

The Specialist Palliative Rural Telehealth service [SPaRTa] is also funded by QLD Health and provides palliative medicine telehealth outreach from four regional hub locations to non-metropolitan areas in QLD which offer training rotations accredited as community terms.

South Australia

Palliative medicine specialist services in South Australia are best described as delivered through a metropolitan outreach model. The adult services are delivered from one of three metropolitan services - Northern, Central or Southern Adelaide, each providing outreach and specialist support to designated outlying regional areas within SA.

Recruitment for entry into advanced trainee positions in South Australia occurs annually by application online to SA Health. All metro services are involved in assessing applications and allocating placements. There are currently no rural placements available in SA.

Tasmania

Palliative medicine specialist services in Tasmania are best described as locally based services.

Adult services are provided by one of three regional services – South [Hobart-based], North [Launceston-based] and North-West [Burnie/Mersey- based. These services are not formally networked.

Recruitment for entry into advanced trainee positions in Tasmania occurs bi-annually by application to the individual service recruiting into a vacancy. Trainees already employed by the Tasmanian Health Service can be re-contracted to a different regional service without the need for new employment applications.

Victoria

Palliative medicine specialist services in Victoria are best described as comprehensive metropolitan and regional services networked through the Victorian Palliative Medicine Training Program [VPMTP].

The Victorian Department of Health has funded VPMTP to provide a coordinated state-wide palliative medicine training program to address the training requirements for specialist palliative medicine physicians, physicians in other specialties, and general practitioners, to build and sustain a high-quality palliative medicine workforce in Victoria.

Recruitment for all positions is managed centrally once a year. If no applicant is matched to a position after this initial round, recruitment shifts to the responsibility of local services advertising to fill vacancies. There is significant competition for prestigious metropolitan placements and some regional services report regularly struggling to fill their trainee quota.

Western Australia

Palliative medicine specialist services in Western Australia are best described as predominately metropolitan, with a hybrid approach to telehealth outreach, visiting specialist clinics and rural generalist networks throughout most of the vast rural - remote areas. To note, a number of the accredited training sites are private providers or public-private partnerships including St John of God, Ramsay Healthcare, Silverchain. Advanced trainee recruitment is managed centrally, and a single employer model is used.

Dr Christine Sanderson, rural palliative medicine specialist, with Fred Miegel, community palliative care nurse, on an outreach visit to an Aboriginal community in the APY lands of South Australia. Credit: C. Sanderson

6. Accreditation

The Australian Medical Council requires RACP to support and document an appropriate training program for the specialty, which it does through the Training Committee in Palliative Medicine [TCPM]. Site accreditation of service and educational infrastructure is one part of the process of standards documentation. (RACP, 2023)

Training positions are accredited as part of the approval of training programs. The main criteria assessed for training are supervision; clinical workload; educational infrastructure; research and exposure to related specialties. Training sites must apply for accreditation which depends on the fulfilment of the requirements and completing the application process. A period of core training will only be approved if it is completed in an accredited training position at an accredited training site.

Accredited Rural Training Sites

To understand various aspects of the metro /rural maldistribution of services, mapping has been undertaken looking at currently accredited advanced training sites, by geography.

Table 5 below shows the number of accredited training sites, by jurisdiction and rurality. Queensland, NSW, and Victoria are the main jurisdictions providing advanced training placements with 28%, 27% and 23% respectively.

Within the overall national training capability, rural locations [MM3-7] accredited as training sites are located in NSW, Tasmania, Victoria, and Northern Territory, totalling 5% of all training locations nationally. 95% of palliative medicine training is offered in major cities and or regional centres.

Accredited sites change regularly are not static, so the following data presents a snapshot at a point in time and can be considered indicative.

Number of accredited adult palliative medicine training positions by jurisdiction and rurality as at Sept 2023.

Jurisdiction	Major Cities MM1	Inner Regional MM2	Outer Regional MM3-5	Remote MM6-7	Total accredited positions by jurisdiction	Percentage of total accredited trainee positions by jurisdiction
ACT	6	0	0	0	6	2%
NSW	61.5	0	9	0	70.5	27%
NT	0	3	0	2	5	2%
QLD	57	14	0	0	71	28%
SA	17	0	0	0	17	7%
TAS	0	5	2	0	7	2.5%
VIC	49	7	2	0	58	23%
WA	17	3	2	0	22	8.5%
Total by rurality	**207.5**	**32**	**15**	**2**	**256.5**	
Percentage of total accredited trainee positions by rurality	81%	12%	6%	<1%		100%

Table 5: Accredited trainee positions [excluding paediatric] by Australian Statistical Geography Standard and Jurisdiction Sept 2023

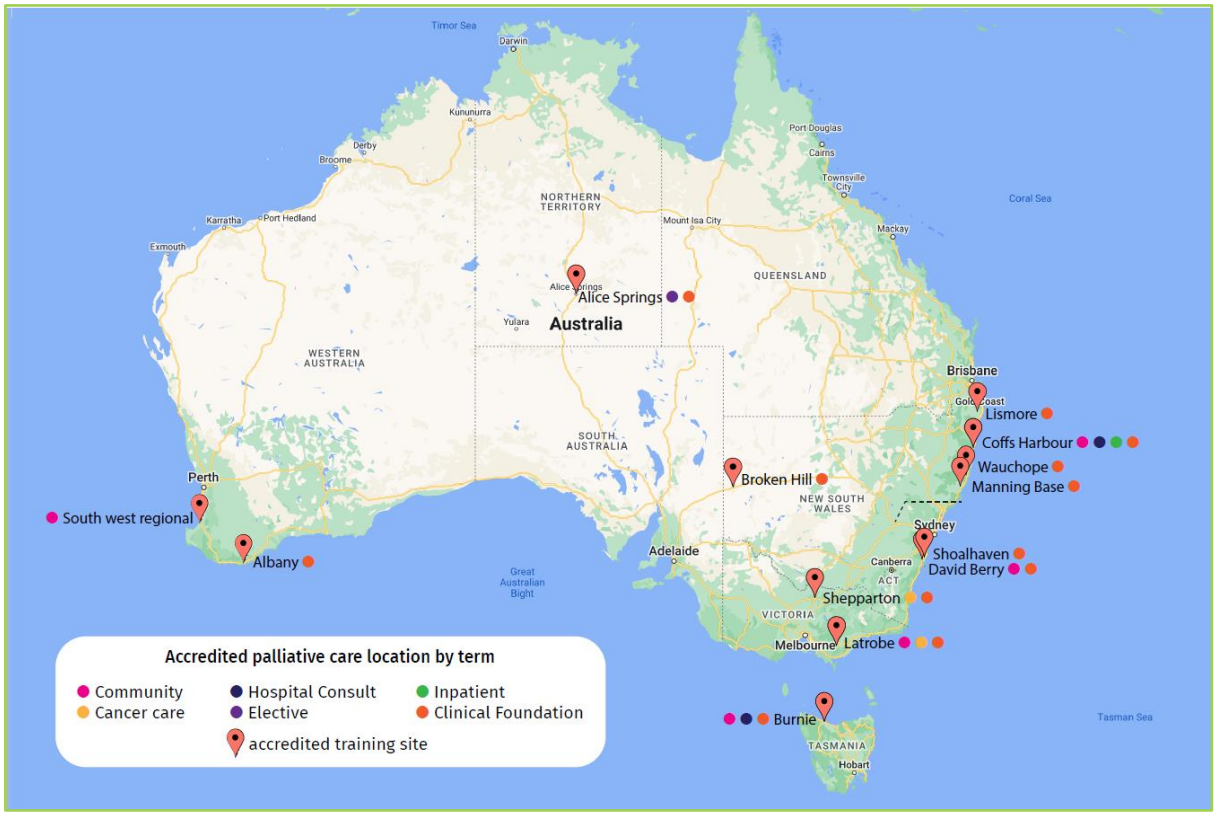

Figure 10: Modified Monash Model 3 – 7 Current accredited rural training sites for palliative medicine by term. [RACP Sept 2023]

Table 6 below lists the accredited terms by location including all accredited training outside capital cities and metropolitan locations, in each jurisdiction across Australia by number of placements available, and rurality. To note, neither ACT, Queensland or South Australia currently have any accredited training locations in MM3 or above. Also, to note, most rural placements are limited to accreditation for Clinical Diploma [CD] only. Southwest regional is an MM2 accredited placement that cover MM3+ areas.

Jurisdiction	Town	Current Accreditation by Term	# trainees	MM
New South Wales	Broken Hill	Clinical Diploma	1	3
	Coffs Harbour	1 Inpatient 2 Community 3 Teaching hospital Clinical Diploma	2	3
	David Berry	2 Community Clinical Diploma	1	3
	Lismore	Clinical Diploma	2	3
	Manning Base	Clinical Diploma	1	3
	Shoalhaven	Clinical Diploma	1	4
	Wauchope	Clinical Diploma	1	3
Northern Territory	Alice Springs	5 Non-core Clinical Diploma	2	6
TAS	Burnie	2 Community 3 Teaching Hospital Clinical Diploma	2 AT Or 3 CD	3
VIC	Shepparton	4 Cancer care Clinical Diploma	1 AT Or 1 CD	3
	Latrobe	4 Cancer care Clinical Diploma	1 AT Or 1 CD	3
WA	Albany	Clinical Diploma	2 CD	3
	South-west regional	2 Community	1 AT	2*

Table 6: Accredited training sites for Palliative medicine training by type and location. (RACP, 2023) **Community term undertaken in MM3+ communities*

7. Consultation findings

This scoping project sought stakeholder input through online consultation, interviews, surveys, and workshops. [See Methodology in Section 1]. An understanding of the barriers to, and opportunities for rural training experience include a combination of system issues experienced by specialists working in the rural sector - operating in the environment into which trainees would be placed.

It also captures trainees experience – which presents a range of different issues. It is important to understand both aspects to consider improvement.

Why do we need a Rural and Remote Institute of Palliative Medicine?

Figure 11: The system is not optimised for rural palliative medicine specialist training.

What attracts specialists and trainees to rural areas?

Half of the graduating medical students coming from rural areas expressed an intention to follow a rural career path. For others, a positive experience during medical training correlates to a greater interest in pursuing a rural career. (Medical School Outcome Database, 2023)

Rural specialists commonly described satisfaction derived from interactions with their patients. The recurrent theme was similarly described by many however is summed up by the following quotes:

> *'…there's a different community culture in the bush…people are appreciative and trusting, and maybe that translates into how you die, or how you accept palliation...'*
>
> *'…patients here, by and large, have a different attitude to life and death. It feels a bit easier- there's a different understanding of nature and death. I find that quite refreshing…'*

Respect and appreciation, and a sense of being valued as an integral part of a multi-disciplinary team was expressed.

> *'…It's less hierarchical here. In some places I've worked…if you're not a professor or have a PhD, then your opinion isn't considered worthwhile. Whereas here, people are more open to listening regardless of rank or station or whatever. That's a real positive, and it's better for patient care and a much nicer environment to work in... '*
>
> *'…We've got excellent nursing support with great nurses and nurse practitioners. And because there's a paucity of medical staff compared to the city… the role of those nurses is a lot better understood, and they're working at the top of their game…'*

Effecting change in complex health systems can be challenging but reportedly less so in some rural locations where rural specialists described a sense of agency and the ability to get things done.

> *'…Everything is smaller. There are fewer layers of bureaucracy to navigate so it's much easier to do things...'*

The opportunity to experience unique environments while delivering rural palliative care in different settings was understood as an attractive option.

> *'…What we offer is unique – there's an outreach service to our Aboriginal patients. We're able to offer remote location outreach into small communities. We're able to offer a fully integrated service. We work with local agencies in really isolated places. Our team is small, and we work across all care settings. It's a great training ground…'*

What are the challenges for rural training?

This section describes system challenges that amount to barriers constraining momentum in rural palliative medicine predominately shared by specialists working in rural locations.

Workforce pressure and sustainability

The concept of workforce pressure and service sustainability was a recurrent theme. A few interviewees described sustainability in terms of how it related to their own personal contribution and their own ability to 'sustain' work pressure.

> *'…we're supposed to get six weeks education training leave per year.... I've taken a week in 10 years. If I tried to take a day off, it wouldn't be a day off, I'd be on the phone the whole time…'*

> *'…about being on call, we don't believe that anything less than a one-in-four roster is workable for the existing staff, because any anything less and those staff burnout…'*

Many considered sustainability from a system view with the potential impact on services. There was a strong sense of system vulnerability, which was frequently raised, and widespread across jurisdictions.

Workforce pressures and the inability to find holiday relief, locums, supervision back up, and pipeline planning for retirement were common concerns.

> *'…I don't get leave cover. They don't get a locum; they don't backfill my position. They just say... bad luck. You're a consult liaison service. Bad luck… and the people miss out…'*

> *'…we used to have specialist clinics- but then I went on sabbatical leave, and it's not restarted since I have come back...'*

> *'…If there's no cover, we have to cut things…'*

> *'…It's sustainable as long as I stay. But if I walk away... then I don't know.... Do they have a service...?*

> *'…there's not a lot of succession planning built into workforce planning…'*

Others viewed sustainability from a resource and funding perspective.

> *'…You cannot build a service based on a one-year funding model…'*

> *'…Until I can get another staff specialist position funded here, I don't think the service is sustainable…'*

> *'…when we've got everybody in post, it works. It's sustainable. Anything that threatens that, someone going off sick for a long time, people taking a sabbatical or long service leave, it leaves us vulnerable...'*

'…we are barely covering what we are supposed to cover, especially when we are covering inpatient beds and in-reach consults. And we're doing community visits, and we're supporting the consultancy services and having only one consultant funded for that – as busy as the service is – that's not right. It's quite easy for them to lose people like me and they go back a few years straight away…'

Understanding rural complexity

Some described a common misconception that rural training was somehow less comprehensive than metro training. Fellows working in rural communities were keen to refute this.

'…in rural areas very often, complexity is not coming from physical symptoms, or pain control and medication management. It's coming from geographic remoteness, socioeconomic disadvantage, Aboriginality, complex family psychosocial dynamics, lack of resources, previous mental health conditions and so on…'

Training, supervising, and managing care in these contexts was described as a rich experience.

'…complexity is not always complexity about the individual receiving care, complexity is also about the skill level and confidence of the provider, regardless of what level. So, it's not a hierarchical thing. It's a peer support, knowledge, capability development thing, and in rural areas there is not layers of other professionals to back you up, so you develop it…'

Understanding rural competency

The nature of competency achieved during advanced training requires consideration. There were divergent views about how, where and what competencies were considered important in rural settings and where best to develop them. The curriculum defines a core set of competencies required for successful completion of training however it was reported to be largely silent on specific rural contexts.

Many training rotations are metropolitan-based and there is no requirement for any rural exposure to complete advanced training. It was largely agreed by rurally based palliative medicine specialists that some exposure to a metropolitan term during advanced training was an important inclusion for all trainees. This would provide some experience with more complex interventions, and exposure to the dynamics of a tertiary or quaternary system. Similarly, though, it was acknowledged that a strong rural experience can be beneficial for metropolitan trainees.

'…some trainees are quite keen to come here [rurally] because they get more exposure to general case load, which is not so protected like in metro terms where you've got very specific teams and a very specialised way of doing things. As a palliative medicine trainee, you need to have generalised exposure rather than being too specialised. Because in rural areas you're not going to be working in a specialised unit. You need to know more broadly about everything…'

'…you don't have readily available support services like in metro. For example, if you're really stuck with a significantly complicated pain situation, you don't have a pain or intervention service waiting there for you to do a referral. You know that when you see somebody, even if you do a referral, there could probably be a week or two weeks waiting time. Until then you need to manage it yourself. You manage patients through a resource poor situation. And you gain more skills and assessment ability. And exposure. In places like ours there's no breast cancer group or no lung cancer group and there never will be….. we become very good all-rounders… '

Rural practitioners point to numerous examples where a metro practitioner's lack of understanding of local rural context has been problematic in translation of care at a local level.

'…the ability for a doctor to manage when everything isn't perfect, when you just have your wits and a few basic items at your disposal. There are a lot of doctors who can function amazingly well in a tertiary centre with everything there. All the sub-specialists are there to help you. But as soon as you add an element of chaos or under resourcing, they can't deal with it. That ability to work with poor resources or resource constraint is a rural competency that has not been well recognised…'

'…how is competence to provide advice [FIFO, outreach] in rural settings measured, when training has been acquired in metro settings? Some of them really don't understand…'

'…This expectation that there was a community team that could drop everything and send somebody was very unrealistic. It stems from the fact that their experience of what a community team is -is based on a metro model. They don't understand the very limited resources in the geography of the area that we're working in...'

'…Most metro folk cannot even fathom what we see. They hear the words we say, but they don't understand the degree of isolation and disadvantage in the population we serve…'

Service isolation and duplicated effort

When considering challenges to developing rural services, FAChPMs describe a sense of service isolation, and lack of professional guidance or support. Examples included individual challenges in applying for funding, or individually navigating steps to achieve accreditation, or convincing funders to allocate resources. There was a sense that everyone was needing to do these same things and it was all happening in silos without any coordination, knowledge sharing or sharing of lessons learned.

'…I wish I didn't have to do it all myself. RRIPM could be the place where we could coordinate those training pathways and resource requests -it could be the organisation that helps, we desperately need that…'

Do the RACP accreditation criteria adequately frame rural training?

Applying for and achieving accreditation was identified as a barrier to training. Many rural sites were potentially eligible for more accreditation and yet had not applied. In seeking to understand the barriers the following explanations were shared.

> *'…We can't get our Hospice job accredited at this point, because we were just half a dozen admissions short of the required number. When we got the required number, they increased the number required again… hugely disappointing, and really challenging to achieve in regional areas…'*

> *'…we're reluctant to even try any more…we had a great learning opportunity – our oncology service had lots of outpatient work, lots of inpatient work, lots of telehealth, a great multi-disciplinary team – it was a Perfect rotation, particularly for someone who's going to end up doing Palliative care medicine, but for the College people to accredit it we needed to try and sell it as something different. It didn't fit into any of their existing criteria, so the opportunity was lost…'*

There were numerous comments about the need for RACP to tailor core term accreditation to align with the more integrated ways of working in rural locations.

> *'… they just weren't willing to consider a mixed term spread over a whole year. There are more than enough over a year, and we don't work in silo's, our work is very integrated. Our registrars are sitting on both the Community MDT and the inpatient MDT. And they share the on call for the whole service - so I really hope the College has enough vision to see the need for flexibility around this. Allowing for an integrated core term is hugely important for rural services…and then people wouldn't have to move every six months…'*

> *'… combined services in rural locations provide a very rich training opportunity and they minimise very bumpy transitions in care that happen in some siloed services- better for the patient, better for continuity, more holistic and better from a workforce perspective but the College won't accredit them …'*

> *'…we need a new category of core term for rural locations MM3 and above – it is neither hospital, nor consultant, nor community – it's all of these combined – and worked over a longer period of time probably 12 months...'*

> *'…The criteria we find most restrictive from a rural remote setting is the required Patient Load. The restrictions about the number of new patient referrals that a trainee must see per year. There are ways around that because it depends how big of an area we're expecting that trainee to cover, if we're including telehealth, and the distance travelled. There are unique and challenging aspects of palliative medicine that come up simply because of the geography of Australia that aren't factored into those patient load figures...'*

> *'…. there doesn't seem to be much consideration given to the situational complexity of rural medicine…'*

> *'… We don't think a term needs to be a six-month placement all at the same time. It could be one week a month over two years…'*

Supervision requirements in a rural context

Supervision requirements were raised repeatedly by interviewees as a barrier to achieving accreditation. The rigid requirements regarding number and availability of FAChPM supervisors present rural services with what is perceived as a Catch-22 situation, where they are unable to train the additional specialists needed to allow them to provide training. There was a common view that systematic changes will be needed to facilitate networked training and supervision in rural areas. There were questions raised about RACP requirements of 'how' supervision is done, and 'who' is permitted to supervise.

The how

'… I think that College needs to get away from this idea that supervision has to be face to face, I think it's really a barrier to getting positions accredited…'

'...modify the supervision requirements and put us in touch with some like-minded individuals happy to work in a more combined supervision model. And utilise the telehealth resources that we're all much more au fait with now. Rather than expecting one supervisor who's working full time to be constantly available to a trainee. Then a supervisor doesn't need to be co-located in the same district or even in the same jurisdiction...'

'…it's a bit of a double standard. I trained in the city, and I rarely had face to face supervision with my consultant – they weren't even there many days … I think the College is saying you need to be available just in case .... and we're saying… you know we're on the end of the phone. There is someone available 24/7, and we can do telehealth with the patient if we need to, and with the registrar there. And there are other medical clinicians under whom the patients are admitted – they're not even under the care of the pall med consultant - so where does ultimate responsibility lie…why can't supervision be more flexible in this term...?'

The who

'… we need to mount an argument for supervision, which is always the rate limiting step. The clinical learning content in these two sites is fabulous, absolutely fabulous. Both services have at least 50% of the patients with non-malignant disease. There's also a very busy oncology service, breast cancer surgery service and a radiation service. It would be possible to do a significant part of the training here, but we can't meet the supervision requirements. The supervision requirements need to be more realistic…'

'…I don't tick the right boxes. I can be a secondary supervisor but not a primary supervisor...'

Many rural FAChPM's are also credentialled to provide supervision for RACGP and ACRRM in their respective advanced skills GP training programs. The supervision requirements of these various training programs are not standardised between each other or RACP.

'… ACRRM does not require their supervisors to be palliative care trained, and that's fabulous cause I think we've got some fabulous and really experienced GPs in all of these hubs who would easily be able to supervise extended skills placements…'

'…if the person was doing advanced skills training accredited through ACRRM or RACGP, a GP VMO could supervise the entire 12 months…'

'… the RACGP were quite happy that the trainee only has face to face supervision from a part time specialist. [0.5] knowing that there were other doctors on the ground with palliative care experience, available if required but RACP said no. You can only have a 0.5 trainee, if that's all you've got specialist boots on the ground, - the irony in a district this size is that my boots are likely to be on the ground four hours away and supervising remotely anyway….'

Visiting specialists and outreach services

Across much of rural Australia, palliative medicine services are delivered by visiting specialists providing outreach from metropolitan centres, which is both necessary at times, appreciated, but also sometimes problematic. In the absence of locally based palliative medicine specialists, an outreach service is essential to support the local nurse led teams. Quality enablers for outreach done well in these contexts have been described by team members as:

'…he visits once a month in person, we have weekly virtual case conferences to follow up the patients he's been seeing, and he has access to the electronic medical record to create that bridge…it works really well, and he's been coming here for a long time so has good relationships with all of the local GPs, and the team know him…'

Alternative views about outreach as a model of care were also expressed.

'… visiting specialists providing a 0.2FTE in reach service, unless they've been coming for years, often don't understand the local context. I mean, I'm sure they're excellent at the clinical complexity. But how do they understand those other aspects of complexity when their usual supports don't exist and so on…?'

Logistically, rural outreach from metropolitan services as a model of care was described as fraught with cost and time inefficiencies.

'…The flights to rural areas are on small planes and the services are often delayed…'

'…I spend a lot of time travelling and less time providing consultation…'

'…Relationships between general practitioners is something that has been difficult to develop for me during outreach visits and may be more advantageous for someone who lives locally. The relationships are important for the continuing care...'

Without comment on the quality of the services provided, allocating resources to continue outreach in an area which could otherwise be resourced to recruit a locally based service provider was identified as a barrier to local service development. Resource allocation to fund outreach services limits the onsite development of local services, and thus limits potential for accreditation of sites as rural training rotations.

A locally based FAChPM is required to supervise a trainee. Where the service is provided by a visiting specialist, sufficient supervision is not possible to meet accreditation requirements for training. This in turn perpetuates workforce pressure in an area that hasn't enabled local infrastructure to 'grow their own' workforce.

> *'… In the past three years I have been approached several times by a local GP wanting to undertake advanced training and be supervised – but I can't do it because I'm fly in fly out – and because I'm fly in there is no other FACHPM here so it's a vicious cycle…'*

Telehealth

Mixed views were expressed about the relationship of telehealth in rural palliative medicine.

The pandemic period led to a rapid uptake and competence in the use of telehealth models of care and large geographic areas of Australia are service by organised and funded telehealth services which provide access to palliative medicine support in outlying communities. Some jurisdictions without this same coverage are looking to telehealth as a possible solution to achieving rural coverage. This review does not have a position on the efficacy or otherwise of telehealth services. It does note the concern raised at interview that telehealth is rapidly being seen in policy circles as a satisfactory "solution" to the challenges of providing rural palliative care. Rural specialists argue that while telehealth technology is a useful tool in the rural toolkit, it does not and must not substitute for a local service with locally accessible multi-disciplinary support and good local knowledge, nor does it enable service development or promote local capacity-building.

Other

Research and teaching opportunities

Centres of excellence in research are evident in Australian palliative care and trainees wishing to engage in those centres are often ranked and competing for placement. Opportunity to undertake supported research during rural placements requires additional support. There are opportunities to link to rural training hubs and a range of universities and collaboratives. Rural fellows spoke of a vision to network and link regular teaching and education, CPD and research activities creating a virtual community of practice. Evidence of this occurring was found in several locations where palliative care services had linked up with others, locally and across jurisdictions to mentor and support each other through shared education sessions.

Mobility and cross border consideration

People in need of palliative care in rural communities sometimes need to travel to their nearest metropolitan centre to access care and this is not necessarily within the same jurisdiction. Crossing borders to access care is common. Similarly, trainees in rural locations are also required to travel, often uprooting family to move to new locations to complete the requirements of their training. Given the limited rural training options currently available, an interstate or metropolitan move appears common. The impact of this shift is experienced as a risk of actual or potential 'loss' of the trainee to the local service and was evident as quite demoralising for the FAChPM supervisors.

Recruitment

Processes of recruitment vary across the nation. Interviewees expressed interest in a process to stream interested candidates into rural training pathways. There was a view that recruitment for rural placement was not well achieved with a centralised metropolitan process. The opportunity to create a defined rural pathway was welcomed.

Funding

Some jurisdictions had received an influx of Commonwealth and state funding for palliative care in recent years and were working through implementation plans to develop services. A few described having service plans placed on hold as the funds were frozen or reversed. Diverse funding sources were described with positions supported through a range of sources including Australian Defence Force; Specialist Training Program; jurisdictional funding both centrally and through local health networks / districts; Health Education Training Institute [in NSW], and various national trials.

Others were experiencing stagnation of their funding and could identify no pathway to support their service's development. Many interviewees described a struggle to access permanent funding to secure positions for their palliative medicine service. In some circumstances, where palliative medicine was delivered as an outreach function from a metropolitan service, the funded outreach positions were described as 0.2 FTE or 0.4FTE for example, providing an allowance for perhaps a monthly outreach visit, and which did not include an option for a trainee to participate, and might be reduced at times when the metropolitan service was itself experiencing resource issues.

While essential to the delivery of care in many rural locations given the current workforce environment, the cost of funding locums and fly in fly out services was said to limit the available funds to recruit locally based providers in some locations.

In most locations, funding for rural palliative medicine was not guaranteed, secure, ongoing, or sufficient to develop local services or effectively meet the needs of rural communities. For example, in Tasmania, only three of ten positions have recurrent Tasmanian Health Service funding. In other locations, funding was available, but the positions could not be filled.

Specialist Training Program [STP]

STP funding presents a significant opportunity to tailor and fund rural training pathways however jurisdictions have reported uncertainty when applying for funding, with asynchronous timing of advanced trainee recruitment activity and funding uncertainty leading to recruitment delays and avoidable vacancies. Department of Health and Aged care is currently reviewing the approach to STP funding.

Figure 11 below outlines current STP funding across Australia. There are 24 STP funded palliative medicine training positions nationally with 21 additional positions on a reserve waiting list if funding were to become available. The majority of currently funded palliative medicine STP positions are in non-rural private settings.

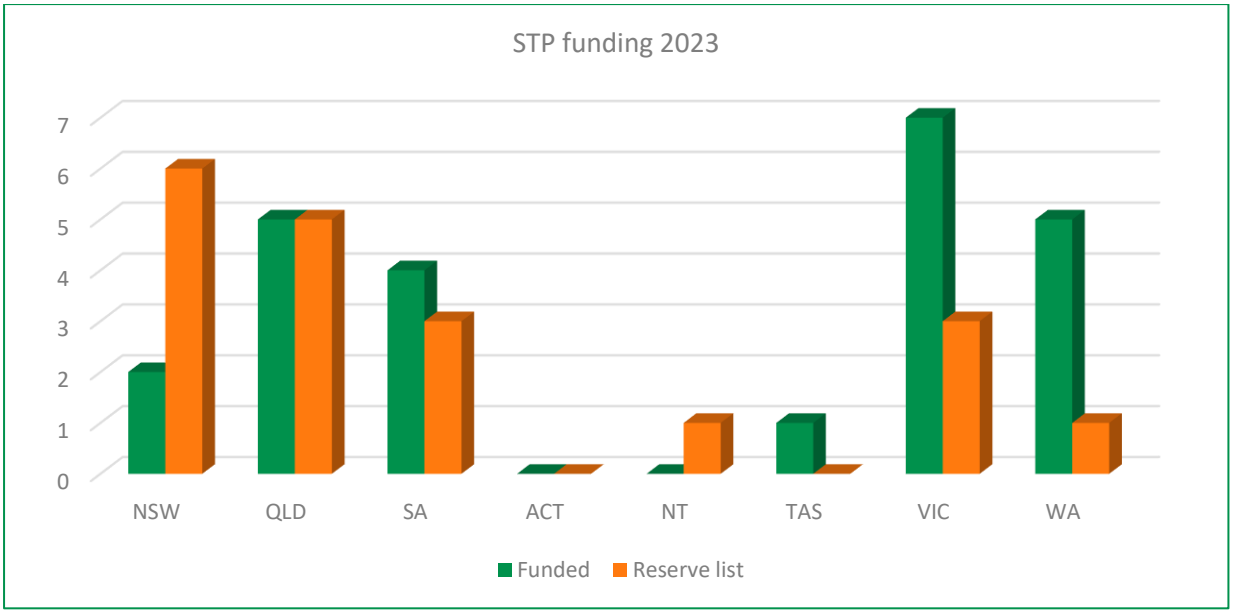

Figure 12: STP funding for palliative medicine positions and reserve list by jurisdiction 2023. Source RACP STP

A recipient of STP funding commented:

> *'… the STP funding tends to be a bit restrictive because a lot of the interested people are GPs who want to do the clinical Diploma not advanced training… so, while the STP funding is great, it does limit who you can put into that position…'*

8. Trainee survey results

The Project Team of the Rural and Remote Institute of Palliative Medicine conducted a survey titled *Advanced Training in Palliative Medicine* via the Survey Monkey Platform. The survey link was open for 20 days between the 8th and 28th November 2023 and access to it was advertised via:

- The Royal Australasian College of Physicians (RACP) trainee mailing list
- The ANZSPM members mailing list (trainee filter)
- The ANZSPM E-Newsletter
- The ANZSPM LinkedIn and X (formerly Twitter) pages
- The RRIPM page of the ANZSPM website
- A QR Code on flyers distributed at the ANZSPM Medical Surgical Conference held in Melbourne 23-24 November.

The survey captured 75 responses from 216 trainees currently registered with the RACP (35% response rate). 20 respondents did not fully complete the survey, 4 respondents from New Zealand were excluded. Just over 50 fully completed responses have been used to reveal insights into the current status quo of palliative medicine training within Australia.

The analysis covers various aspects of the trainees' experiences, preferences, perceived barriers to rurality and their suggestions for how things could be improved.

Question 1: Training Pathways

Most respondents (76%) are on the Palliative Medicine Advanced Training. A smaller cohort (24%) pursues the RACP Dual Training Pathway.

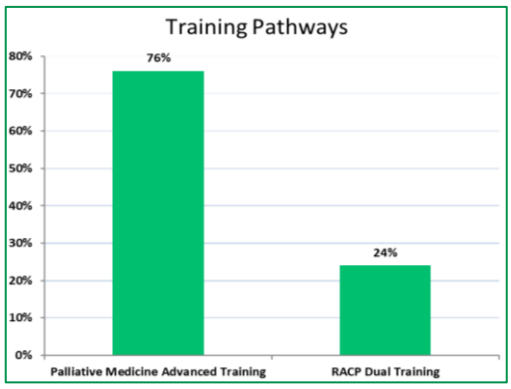

Figure 13: Training pathways

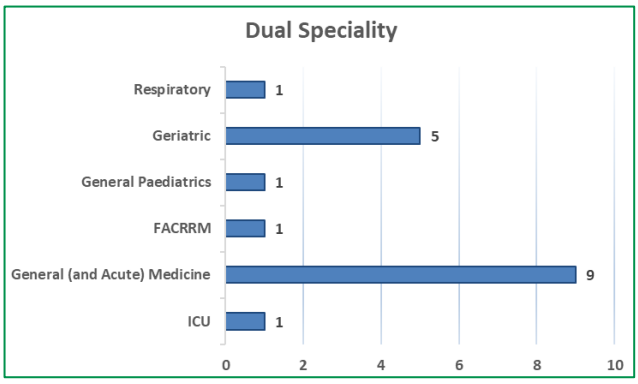

Figure 14: Dual Specialty trainees

Question 2: Terms Left to Finish

Most respondents (63%) are midway through their training, having 1 to 3 terms left before completion.

Question 3: Training Networks

Seventy trainees answered this question. A significant percentage of the respondents (39%) are not training in any network; 16% are with the metropolitan based Sydney Institute of Palliative Medicine (SIPM); 23% are with the Victorian Palliative Medicine Training Program (VPMTP), 10% are training in Queensland; 9% are with the Western Australia network.

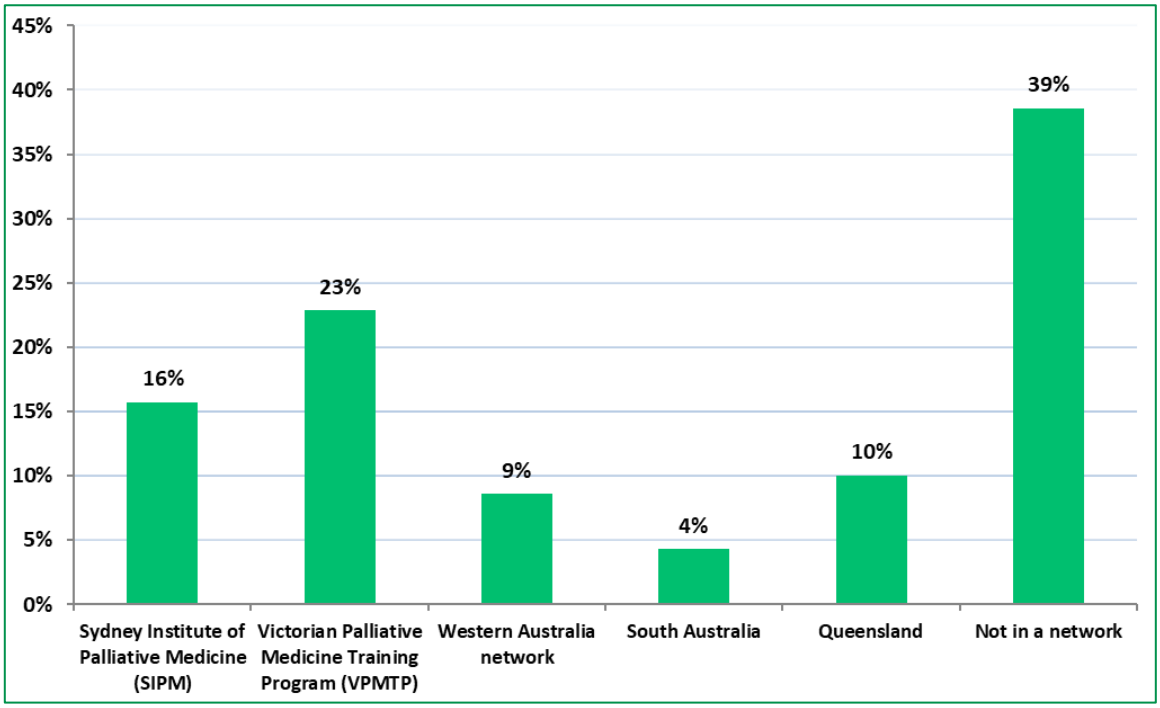

Figure 15: Trainees in training networks

Question 4: Support Currently Provided by Training Networks

Networks operate independently of each other within their jurisdictions and offer a range of support for trainees which differs according to the level of network resourcing. For example, VPMTP is funded through Victoria Health to provide a comprehensive service whereas SIPM does not receive specific funding with support for activities provided by participating services. Networks with allocated funding were described as providing a more comprehensive array of support and benefits for trainees, including:

Protected Teaching:

- Regular face-to-face and online teaching sessions.
- Regular meetings with colleagues, facilitating job sharing and community posts.

Educational Sessions and Guidance:

- Twice-monthly education sessions.
- Fortnightly teaching sessions aiding project work and job-sharing discussions.
- Ensuring all core training terms are covered.

Job Matching and Coordinated Allocation:

- Centralised job matching system reducing stress and time in applying to multiple hospitals.
- Coordinating and allocating positions based on training needs, providing a streamlined process.

Networking and Supportive Environment:

- Opportunities for trainees to interact, share stories, and organise debriefings.
- WhatsApp groups and clear communication among trainees for smoother transitions and handovers.

Less well-resourced networks offered more limited support including:

Centralised Recruitment and Education Events:

- Centralised recruitment for positions.

Regular Teaching and Allocation Assistance:

- Regular teaching sessions and a journal club.
- Assistance from clinical leads in interpreting job positions and ensuring core term allocations.
- Term allocations managed by a training coordinator.

In summary, each network offered varying degrees of support according to jurisdictional resources available. In areas without networks, trainees navigated the training system without this level of support.

Question 5: How Might a Training Network Better Support Trainees?

The suggestions from trainees highlight essential areas where a training network could significantly improve the training experience, including:

Teaching Methods

Offering a hybrid teaching model that combines both in-person and remote access sessions to accommodate diverse learning preferences and geographical challenges.

Providing remote/online access to education sessions would alleviate the burden of travel, particularly for rural and remote trainees.

Networking and Support

Facilitating improved networking opportunities among trainees would foster collaboration and shared learning experiences.

Access to self-care and burnout prevention support signifies a recognition of the mental health challenges trainees may face and the importance of adequate support structures.

Clinical and Educational Support

Ensuring clinical supervision and collaborative discussions among trainees to assist with assignments indicates the need for mentorship and peer learning.

More frequent educational sessions and guidance regarding advanced training, especially with case study presentations and research projects, could enhance learning experiences.

Clinical Exposure and Placements

Prioritising exposure to outreach palliative services, interventional pain management, and improving support for rural and regional placements, to meet trainees' need for diverse clinical experiences.

Supporting trainees in finding accommodation for regional and rural terms, given the logistical challenges of periodic relocation

Advocacy and Policy Changes

Advocating for trainees' needs, including assistance with navigating College requirements, funding for positions, advocating for variations in training to include more rurally focused palliative care requirements, and addressing issues with parental and holiday leave management.

Ensuring guaranteed training rotations and activities aiding the transition to Fellowship to provide a clearer career path for trainees.

Equitable Access to Education

Ensuring better balance in the geographical location of educational sessions by holding them not only in metropolitan hospitals but also in regional settings and providing more online teaching for rural and remote trainees, to provide equitable access to education.

Question 6: Exposure to Regional, Rural, and Remote Settings

Nearly 60 trainees answered this question. A significant number of the respondents appear to have had prolonged exposure (MORE than six months) to settings outside of metropolitan areas during their medical training and professional journey.

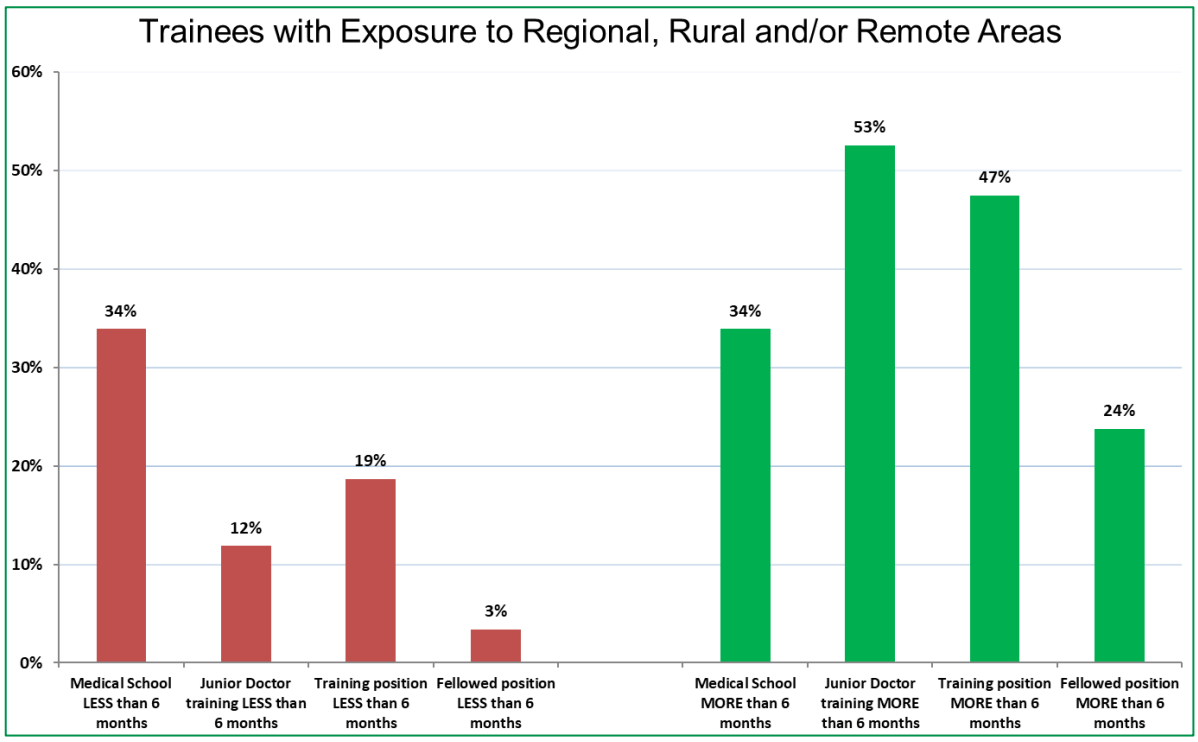

Figure 16: Trainees with regional, rural, remote experience

Question 7: Interest in Training in Regional, Rural and Remote Areas

A considerable percentage of respondents expressed interest in training in regional, rural, or remote areas, indicating a positive attitude towards these settings. Nine respondents were not at all interested.

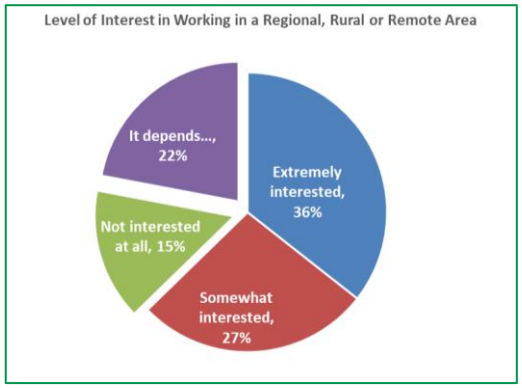

Figure 17: Level of interest in working in Regional, Rural, Remote areas

Question 8. The Barriers to Going Rural

The barriers highlighted by trainees regarding pursuing training in rural Australia offer valuable insight into the multifaceted challenges faced by medical professionals considering or engaging in rural placements. These barriers can be categorised into several key themes:

Family Commitments and Partner's Employment

Family and partner commitments, including their employment, perceived lack of good schooling options for children, and access to childcare

Concerns about relocating families, especially with young or school-going children, and the impact on their education and stability

Job Availability and Relocation Costs

The availability of jobs for partners, especially in non-medical fields, and the financial burden associated with relocating, including paying for temporary rental accommodation plus a mortgage somewhere else

Lack of Training Positions and Specialised Care

Limited or lack of accredited training positions in rural areas, which affects the location, quality, and variety of training experiences available

Concerns about access to specialised training, especially in areas like paediatric palliative medicine and oncology

Social Isolation and Support Networks

The potential isolation from usual support networks, including family and friends, and the distance to travel to access healthcare and support systems were mentioned as barriers.

The lack of knowledge regarding support structures outside metropolitan areas and the perceived inflexibility in education requirements contribute to this sense of isolation.

Uncertainty and Future Planning

The uncertainty associated with temporary relocations, the need to split families, and the difficulty in planning for the long term due to constant moving

Uncertainty about the future, including job availability post-fellowship, networking opportunities, and long-term career prospects, add to the hesitancy in opting for rural placements

Educational and Training Constraints

Educational constraints, such as face-to-face attendance requirements, limited teaching opportunities, and insufficient flexibility in College training requirements were concerns for trainees in rural areas.

In summary, the barriers encompass a wide range of personal, professional, and logistical challenges that impact these largely metropolitan-based trainees' decisions and ability to leave metropolitan centres to pursue training in rural areas. These challenges highlight the need for comprehensive support systems addressing family needs, partner employment, educational flexibility, and the overall logistics of relocations. Addressing these barriers could encourage more metropolitan-based palliative medicine trainees to seek rural experience, or to consider a rural advanced training pathway.

Question 9: What Might Encourage a Trainee to Join a Regional, Rural or Remote Network?

Trainees were asked to consider four statements and attach a level of importance to them. The responses indicate the factors that significantly influence a trainee's decision to join a Regional, Rural, or Remote (RRR) network:

Certainty of having support in placements

Nearly 90% of respondents thought it was very important to receive support, and the kind of support they identified included for example, accommodation, travel logistics and funding certainty.

Peer Support and Education Network

95% of respondents found the opportunity to participate in peer support and education networks very important or somewhat important. This underscores the value trainees place on being part of a supportive community that offers educational opportunities and fosters peer interaction and learning.

Supervision Methods - Remote and Face-to-Face

About 89% consider a combination of remote and face-to-face supervision very important or somewhat important. This indicates a preference for flexibility in supervision methods, acknowledging the value of both remote and face-to-face meetings.

Solely Face-to-Face Supervision

Interestingly, only 15% consider exclusive face-to-face supervision very important, while 53% consider it somewhat important. This suggests a recognition among trainees that while face-to-face supervision might be valuable, they are open to and accepting of alternative supervision methods, including remote options.

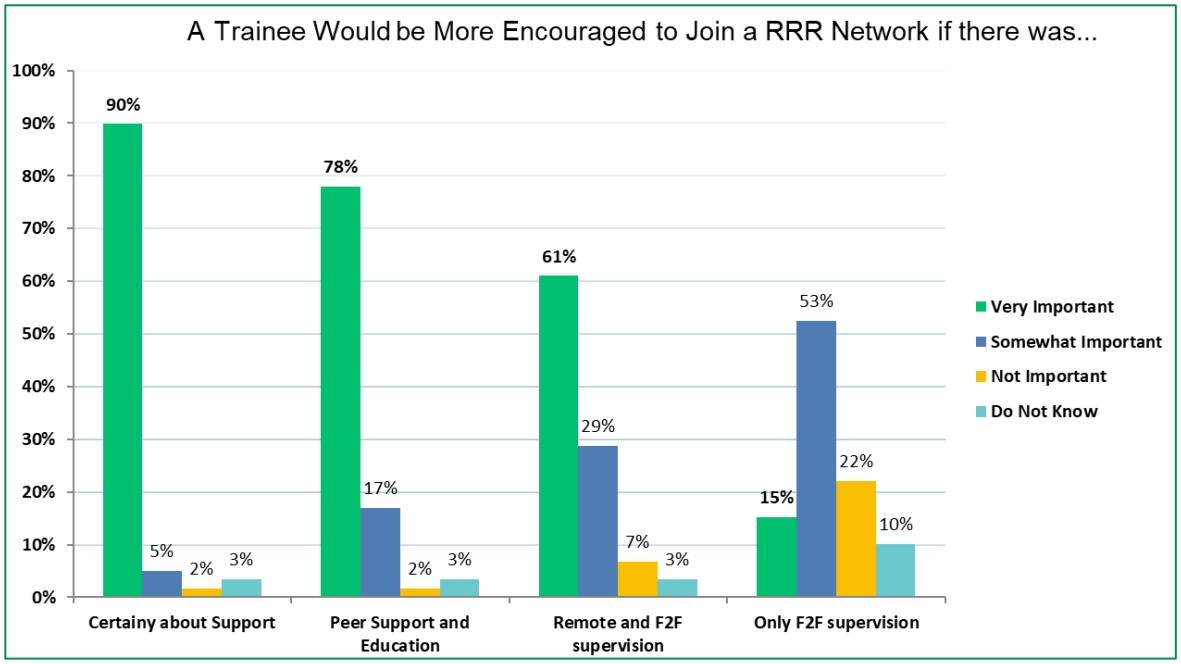

Figure 18: Regional, Rural, Remote incentives

Question 10: Training Placements

Trainees were asked to consider how strongly they feel about the following statements:

- The opportunity for regional, rural, and remote experience during training is likely to be beneficial for advanced trainees.
- The opportunity for a metropolitan placement is likely to be beneficial for advanced trainees.
- Trainees indicated they strongly value exposure to a mix of settings, both regional/rural/remote and metropolitan, during their training. There was strong agreement among trainees regarding the benefits of experiencing different types of placements to achieve a well-rounded training experience.

Question 11: Preferred Work Settings after Training

Trainees' preferences give a clear insight into their first choice and top three preferred work settings after completing their Advanced Training in Palliative Medicine:

Overall, the preferences demonstrate a varied spectrum of desired work settings post-training. While major cities remain the top choice for many, there is a substantial interest in regional centres and rural towns. This suggests a willingness among trainees to explore different practice environments, as well as non-traditional roles like telehealth and academic positions.

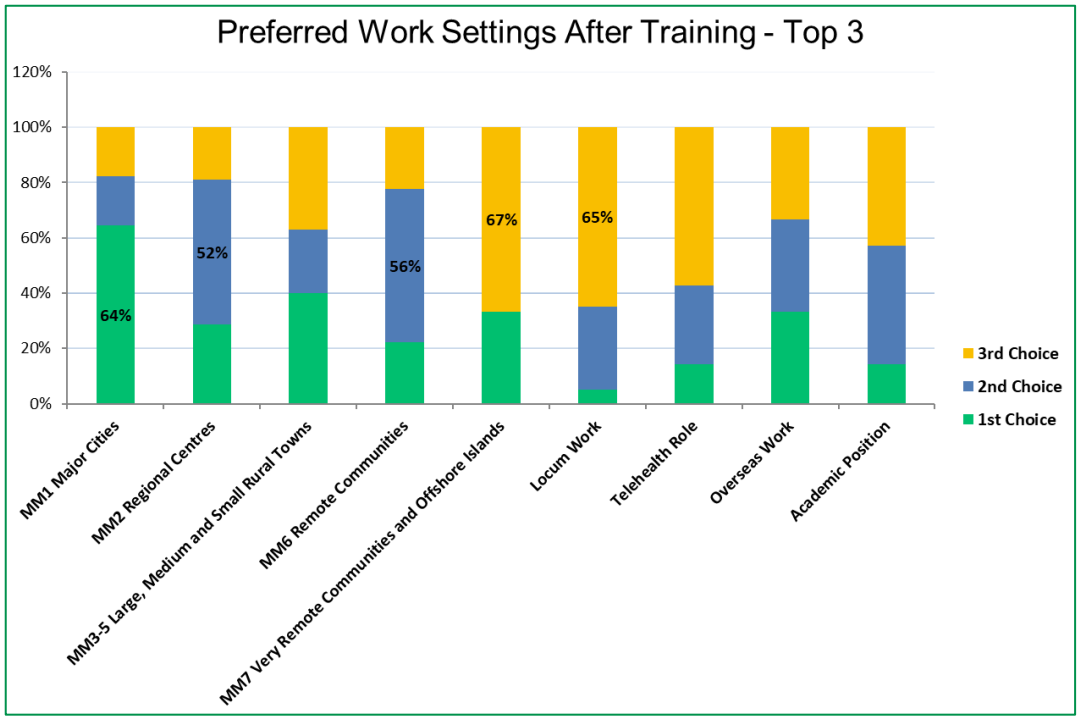

Figure 19: Preferred work setting – Top 3

Question 12: Confidence About Securing a Job After Training

These responses indicate a range of confidence levels among trainees regarding the availability of suitable positions upon completion of their Advanced Training in Palliative Medicine

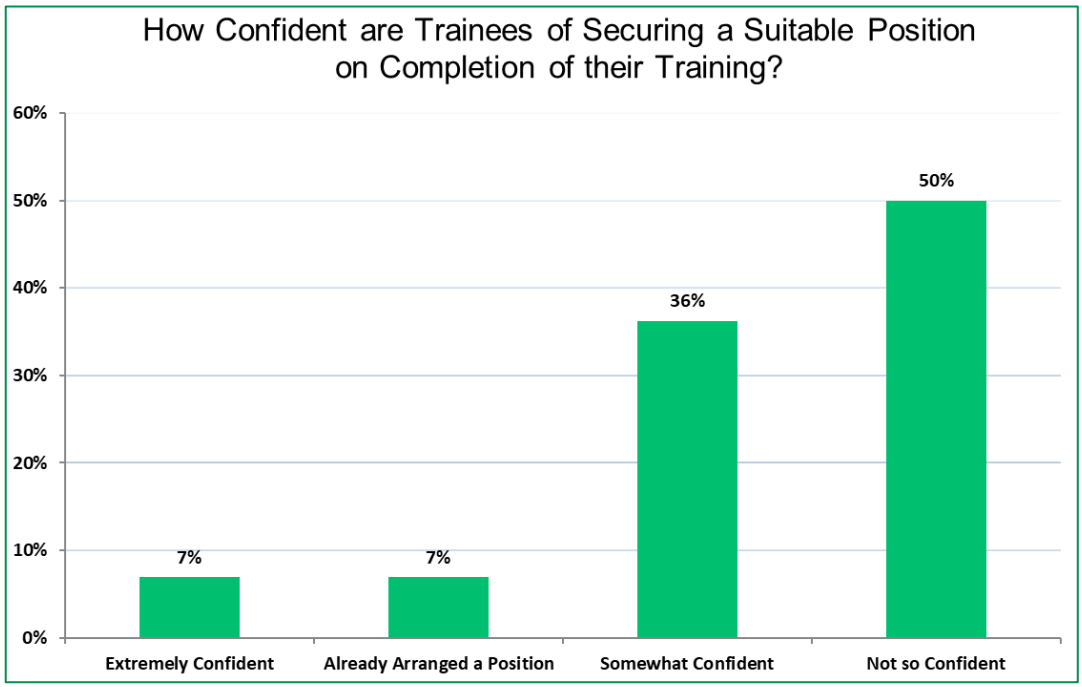

Figure 20: Confidence regarding employment

Overall, the results suggest a prevailing sense of uncertainty or pessimism among a significant number of trainees regarding the availability of suitable positions post-training.

Question 13: Main Considerations when Deciding a Preferred Future Work Setting

In addition to the barriers previously identified about family considerations when choosing future employment options, the most significant concerns related to the work environment and culture.

- **Work Environment and Culture:** The culture of the department, cohesive teams, supportive environments, and opportunities for teaching, research, and continuous learning are crucial factors.

- **Work-Life Balance and Lifestyle:** Considerations for a balanced lifestyle, flexible employment conditions, access to support networks, and proximity to home or familiar settings impact their preferences.

- **Job Availability and Location:** Availability of suitable positions, including the limited job market and the realistic need to go where work is available.

- **Professional Growth and Opportunities:** Opportunities for growth, including financial support for conferences, academic affiliations, research encouragement, and flexible work conditions, contribute to their decision-making.

- **Service Provision and Patient Demographics:** Preferences for specific patient demographics, pathology mix, or service provisions, such as outreach to marginalised communities.

- **Community Impact:** A desire to serve disadvantaged or rural communities and support patient care in remote settings is a driving factor for some trainees.

Overall, these considerations indicate a holistic approach to choosing future work settings, encompassing personal, professional, and societal factors.

Photo: Smoking ceremony for palliative care unit. Credit: C. Sanderson

Trainees who choose to work in rural settings may have the opportunity of immersion in a very different cultural setting, and experiences that are unavailable to their metropolitan colleagues.

9. Analysis and Next Steps

This scoping review has provided the opportunity to consolidate understandings of the critical issues facing rural palliative medicine. Interviews with clinicians have repeatedly confirmed the need to reform current training arrangements to ensure that rural training opportunities and pathways can be developed within a training network. Furthermore, it suggests that despite the many barriers that currently exist, there is interest and general support from the current (metropolitan-based) trainees who were surveyed. Table 7 outlines a range of suggested actions for further consideration.

Summary of issues and suggested actions

Key enablers/ barriers identified	Possible RRIPM action
Rural people / community / culture	• Highlight rural opportunities
Clinical and educational support	• Explore tailored and networked education options
Rural research opportunities	• Partner with rural universities and link multi-site rural research options
Sustainability of workload	• Advocacy / liaise with individual health care services / training sites
RACP accreditation process Limited rurally accredited sites	• Advocacy with / support RACP to review accreditation process • Support individual health care services / training sites with accreditation process
RACP supervision requirements	• Advocacy with / support RACP to review supervision requirements • Support individual health care services / training sites / supervisors with supervision requirements • Support individual trainees with supervision requirements
Rural isolation	• Facilitating networking opportunities with other rural trainees
Funding security for positions	• Advocacy
System navigation and finding rural placements	• Centralised source of information about placements and individual support and guidance. • Advocacy for cross border movement
Support for relocation and accommodation	• Liaise with individual health care services / training sites to coordinate relocation and accommodation needs
Support for families, childcare, community	• Centralised source of information about local community linkers

Table 7: Summary of barriers and enablers with suggested actions.

Many geographically isolated service providers operating across different jurisdictions have not been able to effectively coordinate their activities, despite seeing the benefit of doing so. From this review it is evident that there is willingness to work together to overcome barriers that individually seem insurmountable. There is also appetite to collaborate with the broader rural palliative care sector to enhance rural service provision. Right care, right place, right time.

The findings of this review provide a coherent philosophical starting point for developing the Rural and Remote Institute of Palliative Medicine, and the following principles are endorsed by the RRIPM steering group to guide future work:

The priority is rurality

- Training to be led by rural services
- The aim is to grow the population of rurally resident specialists, and to support the transition arrangements pragmatically in the early stages
- RRIPM will create a national support and advocacy base for rurality in palliative medicine, and for rural palliative care services

Rural training to happen in the right place

- RRIPM will support both free movement within the RRIPM network, and / or training as close to a rural 'home service' as possible, for as much of the training time as possible
- RRIPM will grow flexible and locally responsive training opportunities, and support their accreditation within the RRIPM network

There must be a national / cross-jurisdictional approach to rural training

- RRIPM will work to provide national opportunities for training – advocating to reduce jurisdictional and institutional barriers as much as possible
- RRIPM will seek to develop shared online infrastructure that can support trainees and supervisors across different jurisdictions

Capacity-building is required for sustainability of rural services as well as of individual clinicians

- RRIPM will undertake collaborative workforce planning and advocate for the co-ordination of training of advanced trainees and rural generalists / general practitioners between the relevant Colleges, to create a pipeline of palliative medicine trained generalist and specialist clinicians, matched to local needs.

The roles of a rural coordinating entity – RRIPM

Based on the issues raised and suggestions offered, the establishment of a coordinating entity - the Rural and Remote Institute of Palliative Medicine, appears to be widely supported by the palliative medicine sector. The need for a shared approach to rural advocacy; the linking and networking rural palliative medicine training sites, and the shared vision for a sustainable workforce, all provide a strong incentive for the involvement of rural services in RRIPM.

Streamlining and coordinating rural palliative medicine training will be essential to drive needed change across the national landscape. Roles for RRIPM proposed during the scoping review include:

- Raising the profile of rural palliative medicine as a positive and rewarding career opportunity
- Advocating, negotiating, and liaising with funding bodies, Colleges, rural training hubs, jurisdictional entities, and related organisations to reduce identified barriers to rural training, and assist with securing funding
- Co-ordinating and networking existing local education offerings to support access to education for rural trainees
- Streamlining and sharing recruitment processes for rurally focused trainees
- Supporting trainees and their supervisors to plan and negotiate their individual rural training pathways
- Facilitating peer support, continuing professional development, and mentoring processes for rural trainees and their supervisors, as well as new consultants.
- Facilitating community integration for family / partners / including accommodation and relocation associated with rural placement

Specific opportunities for training reform have been identified

Based on the findings of this scoping review, several key reforms and opportunities are suggested for consideration

- **Rural-specific competencies**
  RRIPM supports the view that the ability to understand the patient's context, optimise their care and make appropriate decisions in a resource-constrained and geographically challenging rural environment is a key rural competency. Curriculum reform needs to address this and other location-specific competencies for training, in order to be fit for purpose for rural trainees.

- **Integrated rural terms to replace some or all the currently defined core terms**
  RRIPM strongly supports the concept of a flexible, integrated rural term to replace some of the current core terms. It is proposed that this should be offered as part of the core advance training requirements within a rural pathway, to be aligned with the new competency-based curriculum

- **Flexibility and modernisation of supervision requirements**
  The metro-centric approach to supervision that is embedded in the training program at present clearly prevents the accreditation of many rural services. To support and grow a rural training network, the College needs to modernise its approach, and include a mix of face to face and remote supervision. Both supervisors and trainees believe that this is not just feasible and acceptable, but also essential to allow rural training to be supported.

- **Accreditation of rural services for training**
  This scoping review reveals that there is significant frustration with accreditation processes from the rural palliative medicine sector. Accreditation requirements reflect a metro-centric perspective in terms of caseloads and the siloing of terms, and they need to be reviewed. RRIPM is keen to assist the College to develop a network accreditation process that will support rural palliative medicine training. RRIPM will seek to propose and contribute solutions to the College that can improve the way accreditation occurs for rural services, including peer contribution to the accreditation process for RRIPM affiliated services seeking to accredit a rotation. RRIPM also identifies a key opportunity to review all current rural Diploma terms on a case-by-case basis, with a view to exploring the possibility of co-accreditation for advanced training for those sites who wish to participate in RRIPM, and which provide appropriate experience for trainees.

- **Co-ordination between specialist and generalist training to ensure a functioning training pipeline for rural palliative medicine**
  RRIPM supports the urgent need to collaborate and develop a shared approach to generalist and specialist training for rural palliative medicine. It is essential to articulate the connections between the Clinical Foundation in Palliative Medicine (RACP), Advanced Skills Training for rural generalists (RACGP/ACCRM), and palliative medicine advanced training pathways (RACP). Ensuring that these training programs function properly together will allow rural clinicians to access appropriate training in palliative medicine at their preferred level and contribute to the ongoing workforce for rural palliative medicine.

- **STP funding for RRIPM training positions**
  In the context of the current reviews of STP funding for rural training positions, RRIPM would advocate for a modification to the STP funding model - to allow a 2 -3-year STP funding commitment to be allocated to individual rural advanced trainees to cover their rotation to rural training positions, regardless of jurisdiction, that are not currently fully funded.

How these reforms might occur will require further discussion, broad collaboration, and partnership with an aim of optimising resources and effort for the greater good of rural communities.

Where might rural training opportunities be expanded?

Possible locations for expanding the training program given suitable resources, workforce funding and accreditation have been identified and will be further expanded pending the outcome of the RACP curriculum review.

State	Town	Cancer care	Community	Consult	Inpatient	Proposed Integrated term
TAS	Burnie	Yes				Yes
VIC	Shepparton		Yes			Yes
	Mildura		Yes			
Northern Territory	Alice Springs	Yes	Yes	Yes	Yes	Yes
	Katherine					Yes
New South Wales	Broken Hill					Yes
	Coffs Harbour			Yes		Yes
	Orange/Bathurst/ Dubbo		Yes	Yes		Yes
	Lismore					Yes
	Manning Base					Yes
	Shoalhaven	Yes				
	Southeast NSW	Yes	Yes			
	Wauchope					Yes
Western Australia	West Kimberley (Broome)		Yes	Yes		Yes
	Great Southern (Albany)	Yes	Yes	Yes	Yes	Yes
	Southwest regional (Bunbury)	Yes	Yes	Yes	Yes	Yes
South Australia	Whyalla	Yes	Yes	Yes		Yes
	Mt Gambier	Yes	Yes	Yes		Yes
	Port Pirie	Yes	Yes	Yes		Yes
	Riverland/Mallee/ Coorong	Yes	Yes	Yes		Yes
Queensland	Mackay					Yes

Table 8: Potential new accreditation sites 2024-2027

10. Conclusion

This scoping review set out to determine the need and feasibility of establishing a Rural and Remote Institute of Palliative Medicine, to ensure a skilled rural palliative medicine workforce for the future.

This future workforce is important because rural populations require access to quality palliative medicine close to home, and existing services are vulnerable in the absence of a sustainable well-resourced workforce plan. Mapping has demonstrated a palliative medicine workforce shortage and a significant maldistribution of specialist workforce between metropolitan and rural communities.

National policy reflects the need to address this issue and the RRIPM project aim is well aligned with this policy intent. The National Palliative Care Strategy identifies the role of palliative care medical specialists as important - not only in the delivery of care, but also in the support and building capacity of other providers in palliative care. (Department of Health, 2018). The National Workforce Strategy 2021-2031 makes clear that to achieve maximum benefit to the community, the medical workforce must be geographically well distributed. Further to this, where a specialty can operate to their full scope of practice outside metropolitan centres, they will be expected to provide training in rural areas.

At a population level, a KPMG economic analysis finds the need for palliative care is growing faster than both the population and the total deaths. Well-resourced palliative care services provide cost savings to the health system overall.

The review demonstrated a concerning lack of rural training opportunities, and this despite medical graduates and palliative medicine trainees expressing an interest in rural career pathways. Sufficient opportunity to train rurally does not currently exist. Barriers to rural training are multi-faceted and encompass individual considerations and system issues.

There is opportunity to make positive change in the distribution of available training placements. RACP curriculum review is currently in progress in which a re-defining of competencies will have flow on effects. It is anticipated [and recommended] to make commensurate changes to training accreditation criteria. This is viewed by the sector as a positive shift away from the current metro-centric volume-based determinants of accreditation which present significant barriers to rural services seeking accreditation. Further, the need for formal recognition of specific rural integrated training terms will be instrumental in increasing training opportunities.

Networking educational offerings will minimise duplication of local effort and streamline access to knowledge and learning, mentoring and support. With these changes, rural palliative medicine specialist training terms will be more accessible and supported for trainees seeking a rural career pathway and more sustainable for the specialists who support them.

National and jurisdictional funding to support rural palliative medicine training placements is unreliable and requires a stable horizon to develop the training pipeline. It is hoped that with growing demand on the health system, the value of quality palliative care will be understood as a positive investment reducing overall system costs, while adding significant human benefit.

The RRIPM function of streamlining and coordinating rural palliative medicine training will be essential to driving needed change across the national landscape. To support this rural pathway, proposed activities of a dedicated Rural and Remote Institute of Palliative Medicine will be co-designed with the sector in coming months.

QUESTIONS FOR CONSULTATION

- Can you comment on the rural training pipeline, and how this can be operationalised to improve the sustainability of rural palliative medicine (p19)? What are the challenges and concerns in relation to the training pipeline that will need to be addressed?

- Can you comment on the *How to grow a palliative care service*: *Place-based model for the development of rural palliative care* (Figure 2)? How valid is it? What issues does this model raise, and how can they be addressed?

- Are there other barriers to enhancing rural specialist palliative medicine training that have not been identified in this report that you are aware of? What strategic opportunities or collaborations can support this agenda?

- Do you have comments or proposals in relation to the opportunities for training reform (p60)?

For consideration, please email any comments to rripmproject@anzspm.org.au up until Feb 13th, 2024.

Appendix 1:

Steering group membership

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Dr Christine Sanderson	NT – Project Lead
Dr Kane Vellar	NT – AIDA representative
Dr Lea Currie	ACT
Dr Louis Christie	NSW
Prof Kirsten Auret	WA
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Dr Odette Spruijt	Tasmania
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Project team	
Dr Jo Risk	Project Manager
Karen Motyka	Project Officer

Tables

Figures

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