# A SHORT HISTORY OF PALLIATIVE MEDICINE IN AUSTRALIA

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## Abstract

Over the past 20 years, palliative medicine in Australia and New Zealand has emerged from an informal network of enthusiasts to become a fully recognised specialty with a comprehensive training program. While the field has developed extensively over the last two decades in terms of knowledge, with great improvements in symptom control and our understanding of the physical, emotional and social journeys of dying people, this paper tells the story of the political and educational challenges that have been faced in the effort to establish palliative medicine as a distinct force within our healthcare system. Doctors are now able to obtain a Clinical Diploma in Palliative Medicine to complement their skills in other fields, or to train for full specialist practice with fellowships from the Royal Australasian College of Physicians or the Australasian Chapter of Palliative Medicine, ensuring palliative medicine will play a significant role in meeting the healthcare challenges of the 21st Century.

*"History is the essence of innumerable biographies"* – Thomas Carlyle

The development of palliative medicine as a distinct specialty in Australia and New Zealand is a process I have been part of for many years. The progress to change in our health system is often far more tortuous than expected and this history describes the processes that gradually unfolded as I remember them. My narrative reflects the reality that memories are inevitably plastic and I am solely responsible for any errors and biases.

## Sense of identity

The story began for me in 1990 when I came from the isolation of North Queensland to the first conference of the Australian Association for Hospice and Palliative Care held in Adelaide. No doubt the pioneering Professors Ian Maddocks, Norelle Lickiss and Peter Ravenscroft, along with many others, had been considering the future of palliative medicine for some time, but my eyes were opened then. In a meeting held in a school room, perched on small chairs, I remember Norelle commenting that "it would take a good 10 years before the specialty was recognised".

The next step was the creation of the Australian and New Zealand Society of Palliative Medicine (ANZSPM), which came into existence in 1993. The founding membership was an iconoclastic group of specialists, career medical officers and general practitioners (GPs), the formally trained and the self-taught, the city slickers and the rural pragmatists, developing skills in palliative medicine and building services in the face of an indifferent, and sometimes hostile, health system.

The initial challenge for ANZSPM was to develop the credibility of palliative medicine in the eyes of the community so that palliative care could be improved and could come to be recognised as a discrete field of specialised practice. Most of the groundwork was done by ANZSPM members across Australia and New Zealand, who daily provided high quality and effective care for dying patients and their families. This activity fundamentally changed community expectations and provided the fulcrum necessary to change the health system.

## The development of training pathways and the creation of the Australasian Chapter of Palliative Medicine

Meanwhile, at the Royal Australasian College of Physicians (RACP), a pathway for sub-specialty training in palliative medicine had been created with the first trainees starting supervised training in 1991. A Specialist Advisory Committee (SAC) was created to manage the three-year advanced training program. As palliative medicine was not on the Federal Government's list of recognised specialties, the Fellows of the RACP who emerged were classified as specialists in "General Medicine". Most trainees worked in Sydney under the umbrella of the Sydney Institute of Palliative Medicine (SIPM), which continues to guide trainees through the variety of inpatient, hospice, consultative and community experiences necessary to create a balanced and skilled specialist. The SIPM program was also open to doctors who were not physician trainees and so, in Sydney in particular, a core of practitioners with specialised experience and focus began to accumulate.

From the late 1980s, pressure was also building for a specialist recognition pathway for experienced doctors in palliative care who did not wish to undertake the full six-year RACP training program. This engendered a vigorous debate within the palliative medicine community. A number of physicians argued that specialist status should only be available to consultant physicians who had completed the academically rigorous, basic RACP training followed by SAC-supervised specialist training. However, others felt that the breadth of experience from across the spectrum of medicine would enrich the practice of palliative medicine as one of the more holistic specialties. In

addition, a number of specialists in other fields, as well as GPs, expressed concerns that the creation of palliative medicine as a distinct specialty with only one entry point may exclude them from their established roles in the care of dying patients.

Over the 1990s meetings were held to address these issues and the decision was made to accommodate the diverse backgrounds of the emerging specialty within the College. The existing and successful RACP fellowship program was continued and a second fellowship pathway created via a new sub-group, the Chapter of Palliative Medicine, within the Adult Medicine Division. The Australasian Chapter of Palliative Medicine (AChPM) was approved by the RACP and came into existence in May 1999. This was a new direction for the College and led to the development of Chapters of Addiction Medicine and Sexual Health Medicine.

Foundation Fellows of AChPM included those who had trained under the SAC in palliative medicine and a number of others who were required to meet admission criteria that were by necessity both broad and rigorous.[1] These criteria recognised that there were a group of experienced doctors who had obtained their skills in palliative medicine in a wide variety of clinical settings, often in the absence of any framework in which they could obtain supervised training, but also ensured that Fellows were practising at the appropriate level of a "specialist". This was essential to demonstrate to the Australian Medical Council (AMC) and the New Zealand authorities that this group was worthy of recognition as specialists. In May 2000, the first Foundation Fellows of the AChPM were presented at the RACP annual ceremony held in the Adelaide Town Hall. By the time the process was completed, 218 had been awarded Foundation Fellowship.

Next came the creation of a committee to supervise those training for Chapter Fellowship. The Chapter program provides advanced training only and has been modelled on the three-year program run by the Palliative Medicine SAC of the College.[2] Unlike entry to training towards the Fellowship of the Royal Australasian College of Physicians (FRACP), which requires successful completion of basic training and the RACP examinations, entry to Chapter training requires that the trainee hold a fellowship of one of a number of clinical specialist medical colleges recognised in Australia and/or New Zealand. Trainees are required to spend 24 months in a variety of palliative medicine posts and at least six months working in oncology (unless having significant prior experience in oncology). The trainee can choose from a variety of elective options for the remaining time. Now all doctors in Australia and New Zealand, whether new graduates or experienced practitioners, have a defined pathway into specialist palliative medicine.[2]

## Recognition of the specialty

These achievements opened the door for the next phase of development of the specialty, recognition by government. The gathering of all specialists in palliative medicine under the banner of the RACP meant that a single application for recognition, and appropriate reimbursement, could be lodged. In New Zealand, the process passed quickly through the Government and the specialty was declared in September 2001. In Australia life was not so simple.

During the mid-1990s the body responsible for the recognition of new specialties, the National Specialist Qualification Advisory Committee, had been disbanded and its responsibilities not handed over to the AMC until 2002. The AMC had not yet developed a process for recognition and was facing a minor deluge of applications, hence the ambitions for palliative medicine were caught up in political and bureaucratic reshuffling.

Luckily palliative medicine would be among the first to be assessed, taking the role of "crash test dummy" for the new process as a compliment. The two-part AMC process required that the case be proved that palliative medicine should be recognised as a medical specialty and an application be made for accreditation of specialist medical training and professional development programs.

The requirements of the full application to the AMC required some speculation as to the economic impact on the health care budget of recognition of the specialty by the Australian Government. The full application[3] was submitted to the AMC in 2004 and included discussion on the:

- development and modelling of the palliative medicine workforce;
- models of palliative care service delivery;
- relationships between specialists in palliative medicine and other doctors;
- place of palliative medicine and palliative care in the health system;
- economic impact of the recognition of specialist palliative medicine on Medicare billing;
- nature of specialist palliative medicine practice, with particular reference to the balance between cancer and non-cancer palliative care;
- costs of training and the capacity of the Chapter/College to train the required number of specialists;
- impact on education in palliative care for other doctors and health workers;
- role of the specialty in the development of standards and protocols;
- claims by palliative medicine of more appropriate and perhaps less expensive treatment at the end-of-life;
- safety for the patient and the community deriving from the practise of palliative medicine and the connection between specialist competence and patient safety; and
- claims that recognition would be essentially cost-neutral for the community where comprehensive palliative care services already exist.

Based on the work of Palliative Care Australia, it is estimated an optimum workforce would comprise about 300 full-time equivalent palliative medicine specialists, practising predominantly in the public sector as part of multidisciplinary teams and in collaboration with their colleagues in other specialties, particularly general practice. There is likely to be a progressive increase in the proportion of non-malignant palliative care.[4]

## Curriculum development

As the AMC application was being developed during 2003, it was apparent that there was a need for a curriculum and syllabus for specialist palliative medicine.[5] This was necessary as a natural part of development of the training program, but also to provide support for the application to the AMC by, for the first time, codifying the roles of palliative medicine specialists.

The curriculum would:

- set down the knowledge, skills and attitudes that define a specialist in palliative medicine and that should be acquired by trainees;
- define the experiential requirements for supervised training;
- describe the supervision and assessment requirements of training; and
- guide career long mentoring, personal supervision and continuing professional development of specialists.

The Curriculum Working Party first met in June 2003 and developed a curriculum based on CanMEDS, the Canadian model for the roles of doctors.[6] The curriculum was based on the literature of adult learning, the experience of the Education Department of the RACP and the syllabuses of palliative medicine from around the world. It was finalised in November 2004, adopted by the Chapter and trialled with trainees in 2005. It is currently being adapted to mesh with the ongoing development of the Basic Training and Professional Qualities Curricula of the RACP as a whole.

Over the past year the Chapter Education Committee has merged with the SAC in Palliative Medicine to create a Combined SAC in Palliative Medicine, which will supervise all future advanced trainees under the one curriculum and syllabus. Although there are a few minor differences driven by the variety of prior experience that Chapter trainees bring with them, training can now be delivered to an agreed high standard. Specialist trainees are able to undertake conjoint training with other subspecialties within the RACP, such as oncology or geriatrics, which appears to be a growing trend.

## Clinical Diploma in Palliative Medicine

The delivery of palliative care has always involved close collaboration between medical colleagues. A number of specialties including general practice, medical and radiation oncology, and geriatrics have also long accepted that a period of time working in palliative medicine enhanced the training and skills of those in their field. In the late 1990s, ANZSPM joined with the Royal Australian and Royal New Zealand Colleges of General Practitioners (RACGP and RNZCGP) and the Australian College of Rural and Remote Medicine (ACRRM) to develop a joint position statement that reinforced the crucial role of GPs for the successful delivery of palliative care.[7]

A working party, with representatives of the AChPM, ANZSPM, RACP, RACGP, RNZCGP, Australian College of Rural and Remote Medicine, Medical Oncology Group of Australia, Faculty of Pain Medicine and Faculty of Radiation Oncology, was formed in 2004 to develop a formal post-graduate training program in palliative medicine for those who did not wish to train to a specialist level. A six-month clinical placement in palliative medicine, modelled on the Clinical Diploma of Obstetrics, was developed and piloted successfully during the first half of 2006. The work was assisted by a grant to the RACP from the Commonwealth Department of Health and Ageing, recognising that the dissemination of the skills of palliative medicine throughout the medical community would improve the quality of the health system. As of August 2006, any doctor beyond their immediate post-graduate years can apply to enrol for the diploma, either as part of their post-graduate specialty training, or at any stage in their career to improve their skills or develop a new interest.[8]

## Workforce needs

Towards the end of 2003 the College was asked to make a submission to the Australian Medical Workforce Advisory Committee on the workforce requirements for specialist palliative medicine, responding to questions on the definition of an optimal specialist service, the requirements for resident specialist practice (urban and rural) and the requirements for a visiting specialist service to rural areas. The responses to these questions were based on the work that had been done as part of work-up for recognition presented to the AMC and the extensive evidence-based standards that have been developed by Palliative Care Australia. The end result was that specialist palliative medicine was incorporated into workforce planning processes for Australia before it had been formally recognised by government.[9]

Most specialities would have difficulty calculating their exact workforce needs into the future and palliative medicine is no different. The Australian Bureau of Statistics publishes population and mortality projections that vary according to underlying assumptions. In addition, there needs to be consideration of new trends in referral and responsibility. With only half of expected deaths (50% of all deaths) being due to cancer, the role of specialist palliative medicine might be expected to grow into caring for those with non-malignant terminal disease, however this might be confounded if the skills of non-specialist palliative care are more widely disseminated into mainstream healthcare. There is no doubt, given existing specialist palliative medicine vacancies across Australia and the world, that there is plenty of scope for more trainees and resources are currently needed for more training posts.

## Final steps

The final authority for the recognition of any new specialty in Australia rests with the Federal Minister for Health, who acts on the confidential advice of the AMC. In November 2005 the Minister, Tony Abbott, formally recognised the specialty. What remained then was for Medicare Australia to incorporate palliative medicine into its regulations and to develop item numbers to accommodate billing, and for those states that maintain specialist registers to include palliative medicine. Only then could individual specialists in palliative medicine become registered to practise under their own banner. On 1 May 2006 the specialty was listed in the updated Medicare Benefits Schedule and the new item numbers became available for use, and by the end of June 2006 the last state had completed its bureaucratic machinations. The job was finished.

## Conclusions

Contemporary palliative medicine in Australia and New Zealand is the progeny of many people. The patients who motivate and encourage, the nurses and other health workers whose meticulous care sets such high standards, the family members who provide their support, the RACP, and of course, those colleagues working in diverse settings and often against much resistance – all have created the credibility that underwrites practice. Most of these people go unsung in any history but, inescapably, palliative medicine in Australasia is their legacy.

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