HIGHLIGHTS FROM THE NATIONAL PALLIATIVE MEDICINE SURVEY

Canadian Society of Palliative Care Physicians Human Resources Committee

Partners
Canadian Medical Association
College of Family Physicians of Canada
Royal College of Physicians and Surgeons of Canada
Technology Evaluation in the Elderly Network

Survey conducted: November 2014
Report date: May 2015

Canadian Society of Palliative Care Physicians (CSPCP) Human Resources Committee:

Dr Susan MacDonald (Chair)
Dr Doris Barwich
Dr Paul McIntyre
Kim Taylor
Acknowledgments to Past Chair Dr. Ingrid DeKock and past member Dr. Christopher O'Brien

Partners & leads

Canadian Medical Association (CMA)
Lynda Buske
Tara S. Chauhan

College of Family Physicians of Canada (CFPC)
Artem Safarov

Royal College of Physicians and Surgeons of Canada (Royal College)
Danielle Fréchette
Carole Jacob

Technology Evaluation in the Elderly Network (TVN)
Dr. John Muscedere
Jackie St. Pierre

Palliative care in Canada

Palliative medicine is a relatively new and evolving field. It is only in the last couple of decades that the palliative care movement has taken hold and begun to flourish, as physicians and the public have come to realize that our entrenched dependence on technology and science has led to unrealistic expectations of cure. Fortunately, there is abundant evidence that an early palliative approach to care, when combined with treatment, provides better pain and symptom management, better patient and family satisfaction and lower system costs than treatment alone.[1-7] Our challenge now is to ensure that all Canadians have early access to quality palliative care, regardless of their diagnosis or where they live.

National campaigns such as “The Way Forward” and “Choosing Wisely Canada” propagate the message that there is choice around end-of-life issues.[1,8,9] With the increasing age of the Canadian population, ongoing efforts to expand palliative care to include symptom management and care for people with non-cancer diagnoses, and the emerging chronicity of cancer management, the number of patients who could benefit from palliative care is dramatically increasing. The current work to bring advanced care planning to the public’s attention and the Feb. 6, 2015, Supreme Court ruling (and public debate) on assisted suicide and euthanasia have thrust palliative care into the limelight.

The question now arises: *How will we provide the service that the public is going to need and demand?*

Why did we conduct a national palliative medicine survey?

Currently not all Canadians have access to palliative care, despite evidence that palliative care provides better pain and symptom management, better patient and family satisfaction, lower system costs and, in some cases, increased longevity.[10] Growing recognition of these factors has raised expectations for access to palliative care across Canada. A sufficient and competent workforce in all health care disciplines, including medicine, will be required.

The objective of the survey was to obtain a snapshot of the palliative medicine workforce today, to:

- create a baseline for future planning
- measure progress
- inform negotiations
- inform a future palliative medicine workforce plan for Canada

How was the survey created and conducted?

The Canadian Society of Palliative Care Physicians (CSPCP) created a Human Resources Committee to determine what sort of palliative medicine workforce the country should be developing. The first action was to create a survey of Canadian physicians. This survey was designed *not* to count the number of palliative care physicians but rather to determine the types of physicians who deliver palliative care, the various fashions in which palliative medicine is practised and the educational process physicians employed to reach their practice level.
The Canadian Medical Association (CMA), the Royal College of Physicians and Surgeons of Canada (Royal College), the College of Family Physicians of Canada (CFPC) agreed to partner with the CSPCP Human Resources Committee to lend their considerable expertise in survey

creation, data analysis and dissemination of results. The CMA was solely responsible for distributing the survey and for creating the database and associated syntax. The Technology Evaluation in the Elderly Network provided financial support and support with information dissemination and knowledge translation, and the Royal College and CFPC provided financial support for translation of the report. These four organizations will be collectively referred to as the partners.

A committee was struck, consisting of representatives from all of the partner organizations, to design a questionnaire that could be used to develop a profile of palliative care physicians in Canada. The survey questions went through multiple reviews with the partners. The survey was piloted with several palliative care physicians and the final product was translated to French so that it would be available in both official languages. Ethics approval was obtained at Memorial University. The questionnaire was mounted online using FluidSurveys software.

There is no database or list of palliative care physicians in Canada. Therefore, the survey was broadly distributed electronically (in November 2014) to all members of the CFPC and Royal College for whom an email address was available (over 60,000 contacts), and an unknown number of other physicians were reached through the partners' efforts to promote the survey. Unique links were assigned to each recipient to ensure that no duplicate responses were captured. A reminder was sent after approximately two weeks' time to those who had not already completed the survey. The survey closed after four and a half weeks in the field.

The survey asked physicians to respond if they do *any* palliative care in their practice. Those who responded were asked a screening question that determined whether or not they met the inclusion criterion for the detailed questionnaire and analysis. It was recognized that because this methodology was used, there would be no known denominator upon which to base a response rate for the eligible population (i.e., the number of physicians in Canada within the scope of this study remains unknown). All potential respondents were assured that their responses would remain confidential and would be reported in an aggregate format only.

Data analysis was provided primarily by the CMA, with additional analytic assistance from the CSPCP, CFPC and Royal College. The data will be securely and anonymously stored with the CMA for 10 years.

Data limitations

There were certain limitations to our methodology that should be noted when interpreting the results.

Physicians who practise palliative medicine in Canada are not necessarily members of the Royal College or the CFPC because membership in these organizations is not required for licensure. Consequently, it was not possible to identify "all palliative care physicians" to whom we should have sent the survey and thus there is no denominator with which to calculate a response rate.

In addition, because the survey mailing list only included members of the two colleges, physicians who were not members of either college could only participate if they became aware of the survey through partner championing and advertising or through word of mouth from colleagues.

Those who did receive the survey were asked to self-identify as to whether they provided any palliative care in their practice. Only those who believed they did provide such care were asked to complete the questionnaire. The act of "providing palliative care" could be interpreted differently from one physician to the next. This limitation, along with the fact that participation was voluntary, means that the total number of responses cannot be used as a proxy for the number of physicians providing palliative care in Canada. Many clinicians whose primary focus is not palliative care include some palliative care as part of their practice. There has been no previous work to determine what percentage of physicians might fall into this category.

The self-reported responses are assumed to be accurate; however, no measures were taken to verify their accuracy. That said, the low social desirability bias of most of the survey questions helps mitigate these concerns. It is also possible that individuals interpreted questions differently.

Terminology

For the purposes of this report, physicians who reported providing palliative care in accordance with a definition provided in the survey are referred to herein as "palliative medicine physicians" (PMPs). Those considered "PMPs" do not necessarily hold a formal qualification nor do they necessarily have full-time palliative medicine practices.

The term "palliative medicine specialist" is commonly used by physicians who practice palliative medicine as their sole are of practice; however, only recently, has formal qualification for palliative medicine been established in Canada. The two formal certifications that can now be sought are (1) the subspecialty in Palliative Medicine recently recognized by the Royal College of Physicians and Surgeons of Canada, which will produce "Palliative medicine specialists" in coming years, and (2) The College of Family Physicians of Canada's Certificate of Added Competence in Palliative Care recognizing enhanced areas of expertise for family physicians, who focus some or all of their practice in palliative care.

Although the term "physician" is sometimes limited to doctors in medical disciplines, in this report it is used in the broadest sense to include all medical and surgical doctors.

The terms "palliative medicine" and "palliative care" are used interchangeably in this report for the sake of simplicity.

Terms used in this report

CFPC	College of Family Physicians of Canada
CMA	Canadian Medical Association
CSPCP	Canadian Society of Palliative Care Physicians
Data Report	National Palliative Medicine Survey Data Report
Others	Physicians who met the inclusion criterion for the detailed survey and analysis, but who are not PC-FFPs or PM sub/specialists
Partners	Organizations that partnered with the CSPCP on the survey project: CFPC, CMA, Royal College, TVN
PC-FFP	Family physicians with a focused practice in palliative care
PMP	Palliative medicine physician, as defined in this survey
PM sub/specialist	Specialists/subspecialists in palliative medicine or pediatric palliative medicine
Royal College	Royal College of Physicians and Surgeons of Canada
TVN	Technology Evaluation in the Elderly Network

Results

The results lend quantitative support to what has been frequently surmised but not previously measured. The data and analyses are summarized in this report. A full report on the data and the complete questionnaire are available as companion documents. All documents will be posted on the partners' websites, including the Canadian Society of Palliative Care Physicians website.

Inclusion criterion

Respondents were asked a screening question that split them into two groups. The screening question was:

Do you practise palliative medicine by:
a) providing palliative care consultations & direct follow-up visits; and / or
b) acting as a palliative care resource to other care providers; and / or
c) providing indirect care as part of a local/regional palliative care service?

Physicians who responded "yes" met the inclusion criterion for the detailed survey and analysis that is the subject of this report. For the purposes of this report, these respondents are referred to as **palliative medicine physicians** (**PMPs**).

Physicians who responded "no" did not meet the inclusion criterion for the detailed survey that is the subject of this report. They may, however, palliate their own patients and they supplement the work of the PMPs. The physicians who responded "no" were asked questions about access to specialized palliative medicine services and their satisfaction with these services. The results are available in the Data Report and will not be reported here.

Of 2,116 physician respondents, **1,114 met the survey-defined criterion for PMPs** and 969 did not. The remaining 33 participants did not respond to the question and were therefore also excluded from this analysis and report.

Types of physicians providing palliative care

Definition of subgroups

For analysis purposes, **PMPs** (*n* = 1,114) were divided into three subgroups:

1. Family physicians with a focused practice in palliative care (**PC-FFP**)**:** *n* = 132
2. Specialists/subspecialists in palliative medicine or pediatric palliative medicine (**PM sub/specialists**)**:** *n* = 51
3. Other physicians (**Others**): *n* = 931

PMPs are a diverse group (Table 1). It important to note that *only a small number of respondents indicated that palliative care is their area of focused practice or their area of specialty*. Physicians who identified themselves as PM sub/specialists comprised less than 5%

of respondents, and those who identified themselves as PC-FFPs comprised about 12% of respondents. Most PMPs (just over 83%) are a heterogeneous collection of other licensed physicians who reported practising palliative medicine as part of their primary practice, such as family physicians, hospitalists and anesthesiologists. In the survey analysis, we defined this subgroup as "Others."

Table 1: Palliative medicine physicians, by description of primary practice

(Q4) Which of these best describes your primary practice?	n	%
Family physician with focused practice in Palliative Care **(PC-FFPs)**	132	12
Specialist/subspecialist in Palliative Medicine or Pediatric Palliative Medicine **(PM sub/specialist)**	51	5
Others: • Family practice including palliative care as part of your primary care practice (n = 577) • Family physician with focused practice in another area (See Table 2.1 for breakdown) (n = 76) • Family practice NOT including palliative care as part of your primary care practice (n = 44)* • Specialist/subspecialist with sub/specialty in another area (See table 2.2 for breakdown) (n = 229) • Did not respond (n = 5)	931	83
Total	**1114**	**100%**

**These 44 physicians did not consider palliative care to be part of their primary care practice; however, their response to the screening question indicated that they met the criterion for the detailed survey and subsequent analysis.*

Table 2.1: Area of focused practice for family physicians with a focus other than palliative care

Area of focus practice	Percentage of respondents (*n*=76)
Hospitalist	22%
Care of the elderly	20%
General practitioner in oncology	11%
Emergency medicine	5%
Other	38%
No response	4%
Total	**100%**

Table 2.2 Area of sub/specialty for those with a sub/specialty other than palliative medicine or pediatric palliative medicine (top 5 shown here)

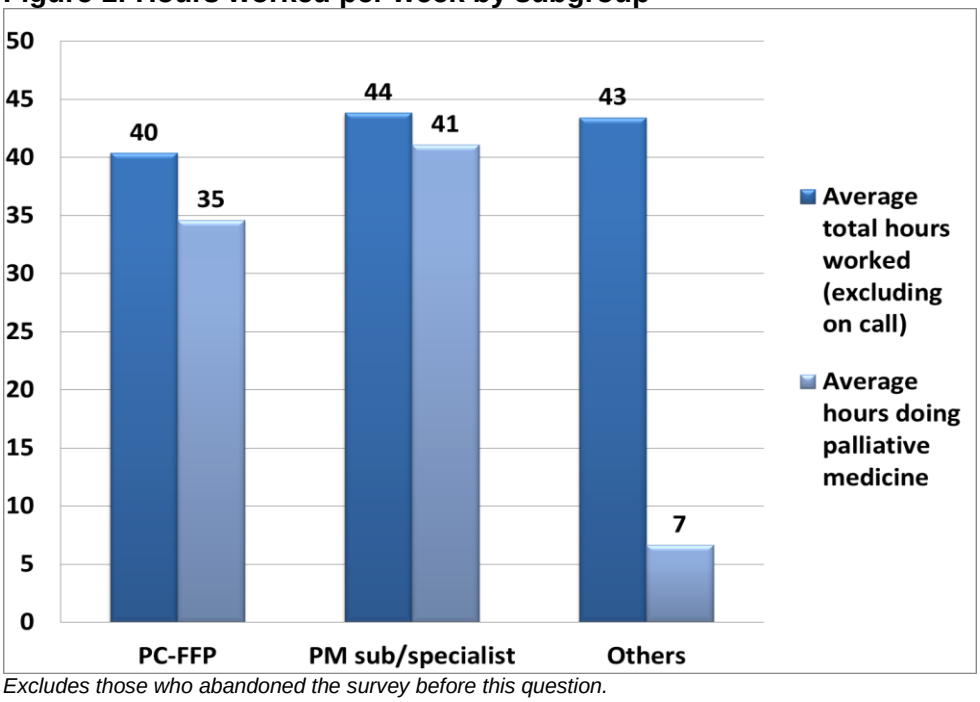
Area of sub/specialty	Percentage of respondents (*n* = 229)
Anesthesiology	11%
Radiation oncology	11%
Pediatrics	11%
General internal medicine	9%
Medical oncology	6%
Over 30 other sub / specialties (all <5% each)*	51%
No response	1%
Total	**100%**

see data report for details

Hours worked in palliative medicine

On average, PC-FFPs and PM sub/specialists devoted over 87% of their working hours to palliative medicine, while those in the Others subgroup devoted an average of 16% of their working hours to palliative care (Figure 1). This is significant when assessing the capacity of the palliative medicine workforce because about 84% of respondents were in the Others subgroup.

Figure 1: Hours worked per week by subgroup



Excludes those who abandoned the survey before this question.

Age

As shown in Table 3, one-third of PMPs are age 55 or over. About 40% are under age 45.

Table 3: Average age of Palliative Medicine Physicians

Age Group (years)	Percentage of respondents (*n* = 1114)
34 and under	**13%**
35-44	26%
45-54	26%
55-64	24%
65 and over	9%
Unknown	2%
Total	**100%**

Training

The majority of the PMPs who responded to the survey stated that they do not have formal training in palliative medicine. While most PM sub/specialists (88%) and PC-FFPs (75%) reported having completed an accredited training program in palliative care and/or a non-accredited training program, 64% of the Others subgroup reported having no accredited or unaccredited training in palliative medicine (Table 4). This is significant because the Others subgroup is by far the largest. It is also surprising since palliative medicine is a key aspect of the comprehensive family medicine residency training and majority of the Others group are family physicians. The data collected signals a need for an enhanced role of palliative medicine in physician education across specialties as well as improved CPD access in the area.

Table 4: Training in palliative medicine, as reported by palliative medicine physicians

		Palliative care practice, by subgroup			
		PC – FFPs (*n*=130)	PM Sub/specialists (*n*=51)	Others (*n*=883)	Total (*n*=1064)
Completed an **accredited postgraduate training** program in palliative medicine	Yes	38%	57%	5%	12%
	No	61%	43%	94%	87%
	NR	1%	0%	1%	1%
	Total	100%	100%	100%	100%
Completed **other training** in palliative medicine	Yes	44%	39%	31%	33%
	No	56%	61%	68%	66%
	NR	0%	0%	1%	1%
	Total	100%	100%	100%	100%
Comparison of respondents who report **no** accredited postrgraduate training with those who have **some** accredited postgraduate training or other palliative medicine training*	Has **no** palliative medicine training	25%	12%	64%	56%
	Has accredited postgraduate training and/or other palliative medicine training.	75%	88%	35%	43%
	NR/Unknown	0%	0%	1%	1%
	Total	100%	100%	100%	100%

NR = no response

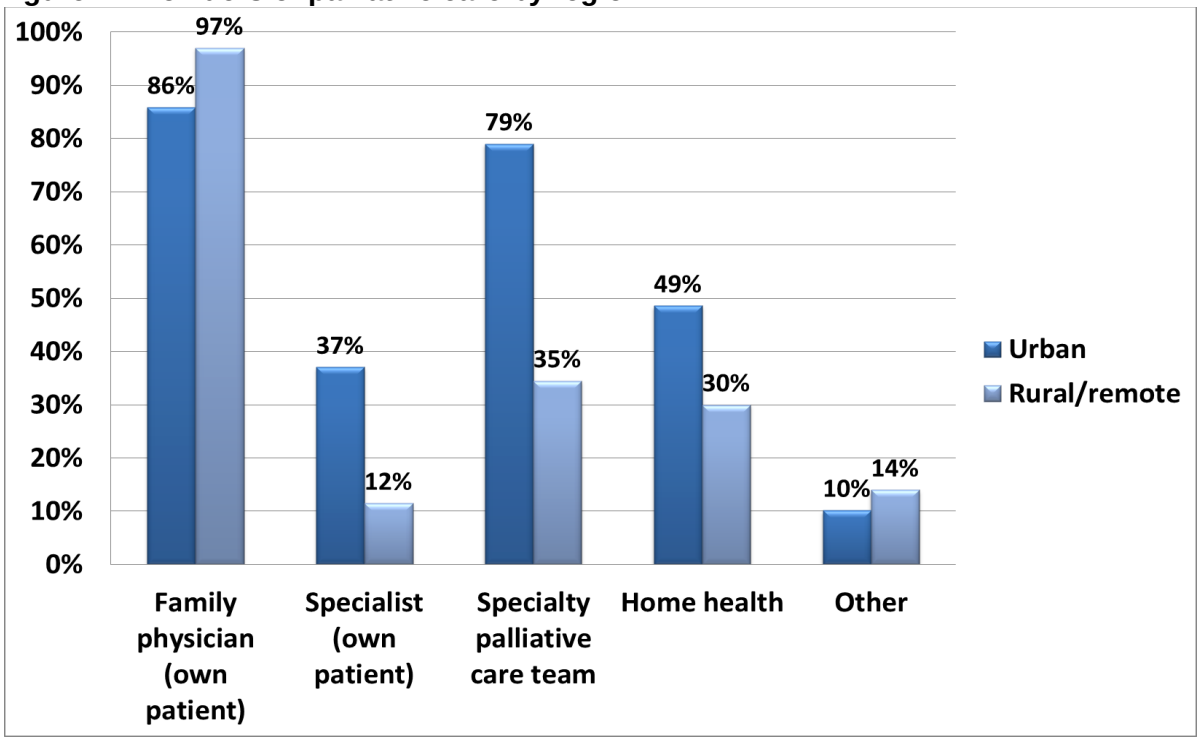
**Analysis derived from response to two questions regarding educational achievements in palliative medicine*

Providers of palliative care

Urban areas versus rural/remote areas

Respondents were asked to define themselves as working in an urban or rural practice. The results show a striking difference between urban and rural/remote settings. In rural/remote areas, palliative care services are provided primarily by family physicians, who provide care to their own patients, and to some extent by palliative care specialists and home health services. In urban areas, palliative care specialists, specialty palliative care teams and home health services are more commonplace (Figure 2).

Figure 2: Providers of palliative care by region



Excludes those who abandoned the survey before this question. Totals of providers may exceed 100% as this question allowed for multiple responses.

Similarities and differences across provinces and territories

The survey results indicated that family physicians are the type of physician who most commonly provide palliative care in all provinces. The availability of specialty care teams for patients was reported to be highest in Nova Scotia and Alberta. Quebec stands out for being most likely to provide home health services (see the section entitled Providers of Palliative Care within Your Region in the Data Report).

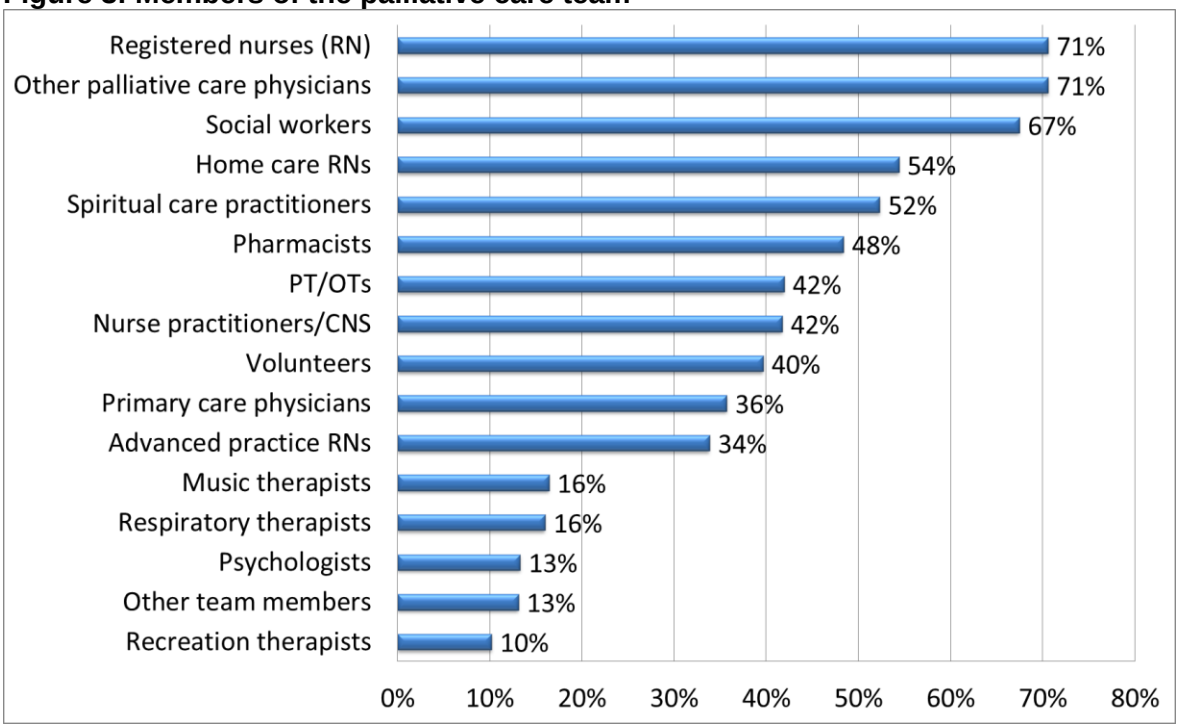
Interdisciplinary teams

The philosophy of palliative care embraces the provision of interdisciplinary care. Ninety-one percent of PC-FFPs and 92% of PM sub/specialists reported that they were part of an interdisciplinary team, but only two-fifths (39.5%) of the Others subgroup reported working within a team. More than half of physicians (52%) serving urban populations reported working

within an inter-professional palliative care team compared with a third (34%) of those who work rurally (see the section entitled Interprofessional Palliative Care Team in the Data Report).

Many different types of health care providers are considered to be on the palliative care team. Those most commonly mentioned by the respondents were other palliative care physicians, nurses (advanced care nurses, nurse practitioners and other nurses) and social workers (Figure 3).

Figure 3: Members of the palliative care team



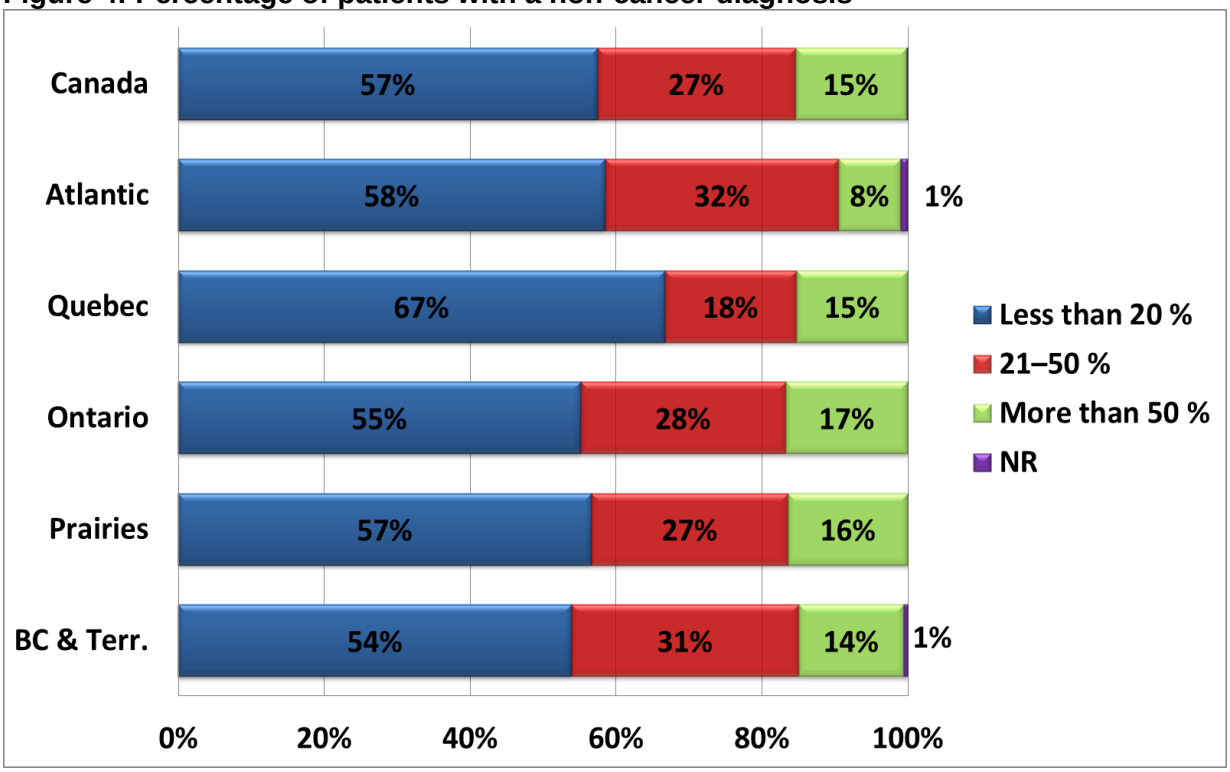
CNS = clinical nurse specialists; PT/OT = physiotherapist or occupational therapist.
Includes only respondents who reported being members of an interdisciplinary team.
Excludes those who abandoned the survey before this question.
Totals exceed 100% as this question allowed for multiple responses.

Patients served by palliative medicine physicians

Cancer versus non-cancer diagnosis

Palliative care was initially offered primarily to oncology patients but over the last decade it has been increasingly offered to patients with other conditions. We asked physicians what percentage of their palliative patients had a non-cancer diagnosis. Nationally, 57% of PMPs reported that fewer than 20% of their palliative patients had a non-cancer diagnosis. Regional differences are shown in Figure 4.

Figure 4: Percentage of patients with a non-cancer diagnosis



NR = no response.
Excludes those who abandoned the survey before this question.

Palliative care for children and youth

Seventy-eight percent of respondents indicated they did not see patients under the age of 18. Most PMPs (64% of non-pediatric PMPs) indicated a lack of comfort with providing palliative care to children. Few respondents, even among those who reported specializing in pediatrics or pediatric palliative care, indicated that they were part of a formal pediatric palliative care team. Not surprisingly, pediatric specialists saw more children per year than non-pediatric specialists (Table 5).

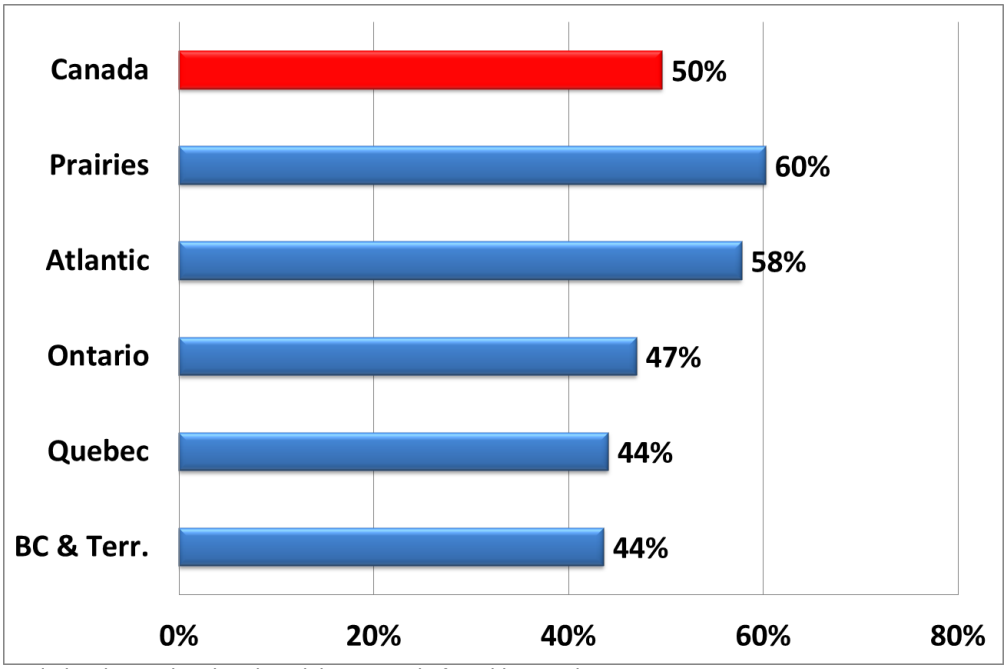
Table 5: Number of children (up to age 18) seen per year for palliative care services

		Pediatric specialists and pediatric palliative care specialists (*n*=34)	Other specialists (*n*=31)	GP/FPs (*n*=134)	Total (*n*=199)
Mean no. of children seen		56	17	5	16
Percentage of respondents estimating they see:	1 or 2 children	6%	55%	76%	61%
	3-9 children	29%	23%	19%	21%
	10+ children	65%	23%	5%	18%
	Total	100%	100%	100%	100%

Includes only respondents who indicated seeing at least one pediatric palliative care patient.
Excludes those who abandoned the survey prior to this question.

Fifty percent of PMPs across Canada indicated that they did not have access to a pediatric palliative care service (Figure 5). This is a surprising result because many provinces have provincial pediatric palliative care programs, such as provincial pediatric palliative care centre(s), and/or they have pediatric palliative care consultation teams. It is possible that some palliative care physicians are not aware of the services offered in their jurisdiction or that respondents interpreted "access" differently. For example, a respondent may have felt that sending a child and family to another community does not constitute having "access."

Figure 5: Percentage of physicians reporting access to specialized pediatric palliative care services



Excludes those who abandoned the survey before this question.

Distribution of time in palliative medicine practice

Respondents were asked what percentage of their palliative medicine practice was spent in various activities (Table 6.1). Respondents in all three subgroups spent most of their palliative medicine practice doing clinical work. Both PC-FFPs and PM sub/specialists spent about 12% of their time in administrative/leadership activities and a similar proportion of time in teaching (14% for PC-FFPs; 12% for PM sub/specialists). Respondents in the Others subgroup spent somewhat less time on administration and teaching. Further analysis (Table 6.2) shows that physicians who worked more hours per week doing palliative medicine spent a higher percentage of their time on administration and teaching.

Table 6.1: Mean percentage of palliative medicine practice spent in various activities, by subgroup

Activity	Mean percentage of palliative care practice time, by subgroup			
	PC-FFPs (*n*=128)	PM sub/specialists (*n*=51)	Others (*n*=811)	Total (*n*=990)
Clinical work	72%	69%	86%	83%
Administrative/Leadership (including committee work)	12%	12%	5%	6%
Teaching and Education (at bedside and formal)	14%	12%	8%	9%
Research	2%	7%	1%	2%
Total	100%	100%	100%	100%

PC-FFP = family physicians with a focused practice in palliative care;
PM sub/specialists = specialists/subspecialists in palliative medicine or pediatric palliative medicine.
Excludes those who abandoned the survey before this question or who did not respond to this question.

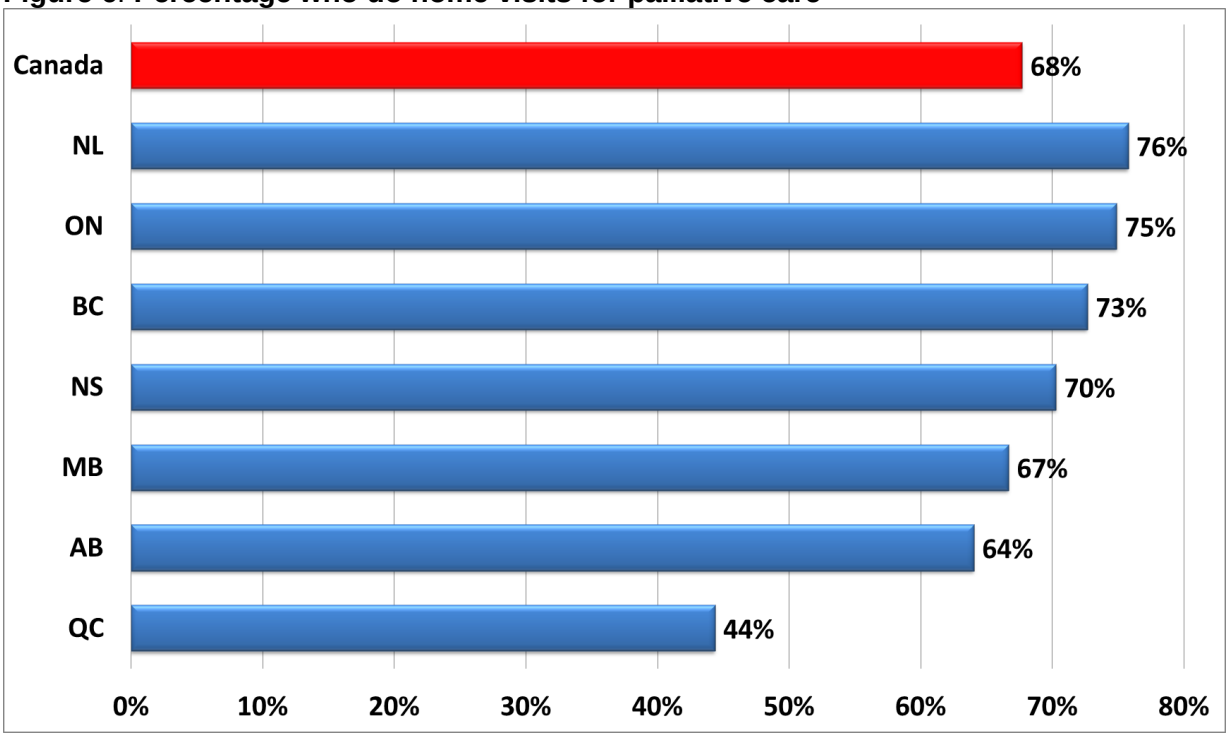
Table 6.2: Mean percentage of palliative medicine practice spent in various activities, by number of hours per week spent in palliative care

	Mean percentage of palliative medicine practice spent in various activities, by no. of hours per week spent doing palliative medicine			
	1-4 h (*n*=475)	5-25 h (*n*=336)	26+ h (*n*=169)	All respondents (*n*=980)
Clinical work	90%	81%	69%	83%
Administrative work and leadership (including committee work)	4%	7%	12%	6%
Teaching and education (at bedside and formal)	6%	10%	14%	9%
Research	0%	2%	5%	2%
Total	100%	100%	100%	100%

Excludes those who did less than one hour of palliative medicine per week.

Two-thirds of PMPs reported doing home visits. In rural settings, 79% indicated they saw patients at home. Slightly fewer PMPs in urban settings offered this service (66%). The data were further broken down by province (Figure 6). It is important to note that there is variability from province to province, underscoring the lack of national standards. There is also a wide range in variability among the provinces in extra fee payment for home visits and payment for mileage.

Figure 6: Percentage who do home visits for palliative care



Excludes those who abandoned the survey before this question. There were too few respondents in Saskatchewan, New Brunswick, Prince Edward, and the Territories for their responses to be considered statistically reliable.

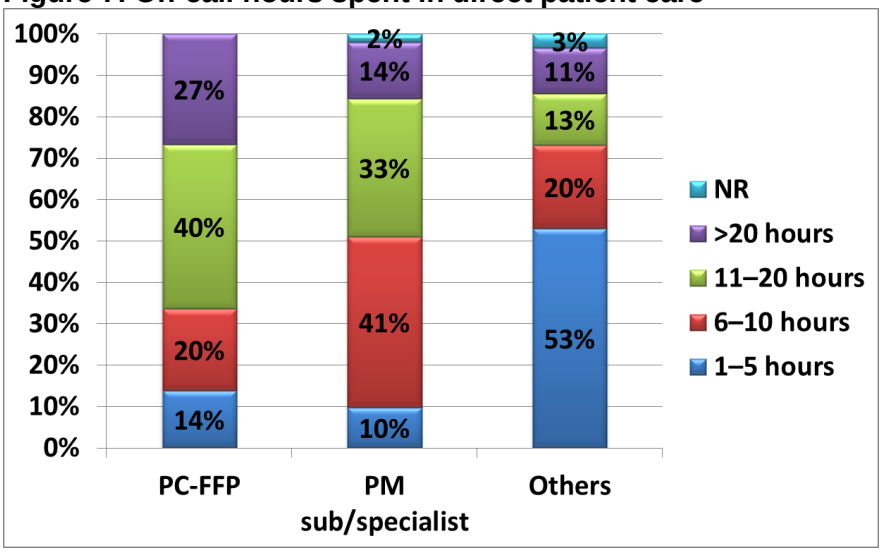
The majority of the PMPs indicated that they provide telephone advice/information to other physicians and health care providers (60%). Urban physicians were more likely to provide this service (62%) than rural physicians (51%).

After-hours care and on-call work

All PM sub/specialists (100%) and the vast majority of PC-FFPs (91%) reported providing after-hours care and on-call palliative care services, while 70% of physicians in the Others subgroup reported doing so. Of those who indicated doing on-call work, the majority in all three subgroups indicated they were part of a call group, although again physicians were less likely to be part of a formalized group if palliative medicine was not their main area of work (60% for the Others subgroup versus 90% for the PC-FFP subgroup and 94% for the PM sub/specialist subgroup. The PC-FFPs (85%) and PM sub/specialists (75%) both did in-hospital rounds for a palliative care unit when on call but a far smaller proportion of the Others subgroup (41%) had that responsibility.

The PC-FFPs and PM sub/specialists differed in terms of the number of hours on call during which they had face-to-face with patients. The PC-FFPs appeared to be more likely to provide more than 11 hours of direct patient care per month while on call than the PM sub/specialists. Physicians in the Others subgroup were likely to spend considerably fewer hours with their patients while on call than either of the other subgroups (Figure 7).

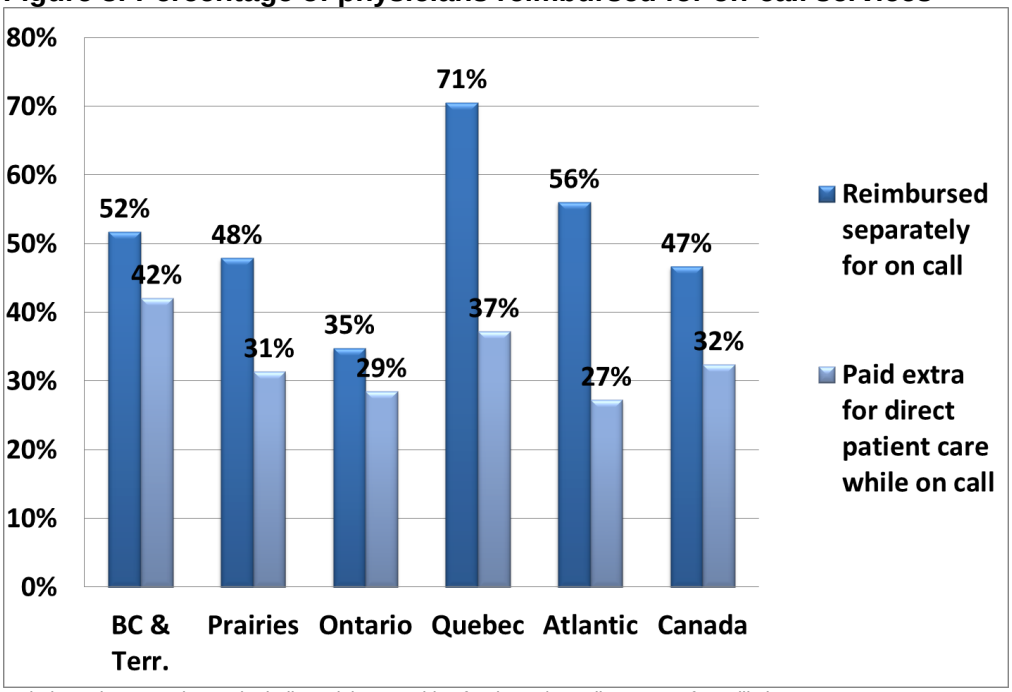
Figure 7: On-call hours spent in direct patient care



NR = no response.
Includes only respondents who indicated they provide after-hours/on-call coverage for palliative care.
Excludes those who abandoned the survey before this question.

There was significant variability between provinces regarding reimbursement for being on call (Figure 8). The majority of the respondents did not receive any extra compensation for face-to-face visits while on call. Each province and territory has a different remuneration structure for both regular hours and on-call work.

Figure 8: Percentage of physicians reimbursed for on-call services



Includes only respondents who indicated they provide after-hours/on-call coverage for palliative care.
Excludes those who abandoned the survey before this question.

Teaching

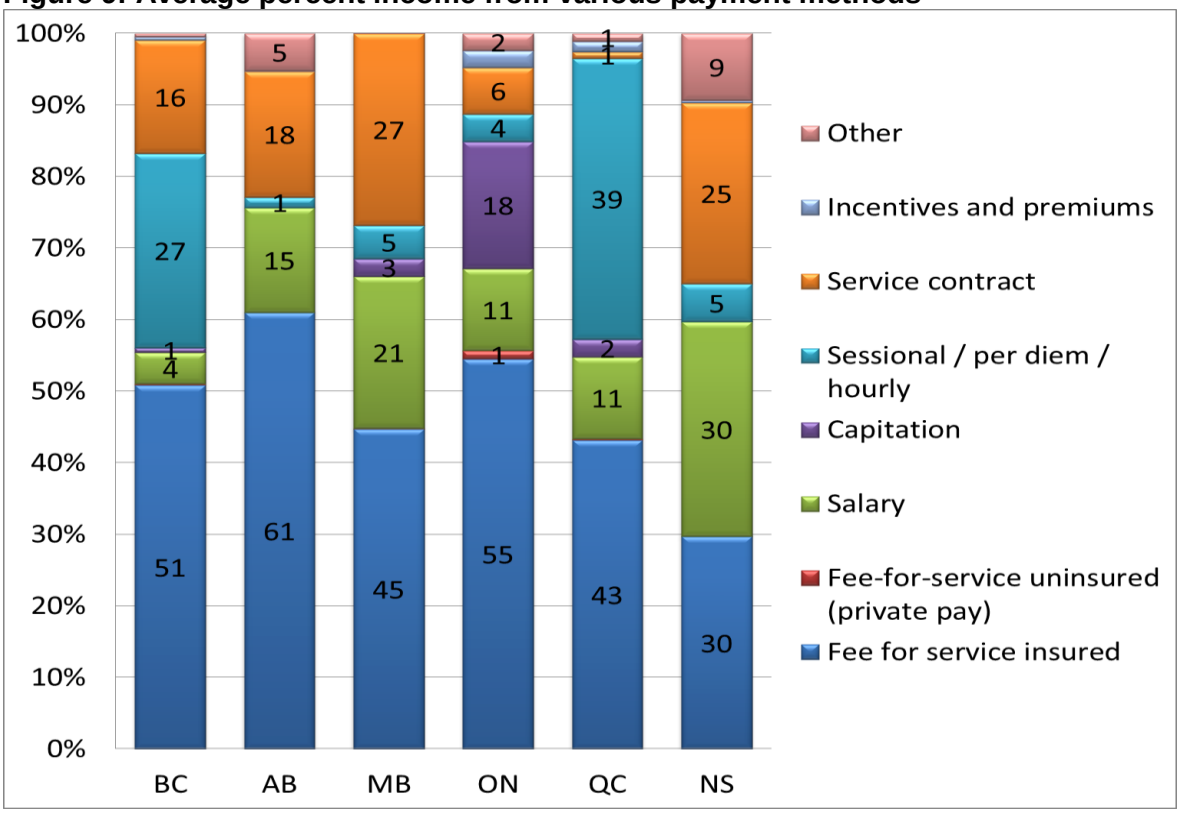
One of the key tenets of palliative care is teaching. PMPs teach the patient, the family and other health care practitioners, who may not understand or be familiar with the normal course of the illness, what to expect and what can be done to help. It is therefore not surprising that many PMPs include teaching as part of their job. Seventy-nine percent of the PC-FFPs and 78% of PM sub/specialists noted they had an academic appointment; we did not ask which field of medicine the appointment was in. Respondents in the Others subgroup were less likely to have an academic appointment (62%). Those who had gone on to obtain training in palliative care, whether through an accredited or non-accredited program, were slightly more likely to have an academic appointment (69%) than those who did not (61%). Seventy-one percent of those who completed an accredited postgraduate training program had an academic appointment (see the section entitled Academic Appointments in the Data Report).

Although most of the respondents indicated they spent time in teaching and academics, very few (18%) had any protected academic time for teaching or research.

Compensation models

Remuneration for palliative medicine services varies widely across the country and is dependent upon a number of factors. Physicians may be paid through a variety of methods, including fee for service, salary, session fee and contract. Figure 9 shows the proportion for each type of payment reported by province.

Figure 9: Average percent income from various payment methods



Excludes those who abandoned the survey before this question. There were too few respondents in the provinces not shown for their responses to be considered statistically reliable.

Remuneration

The majority of the respondents stated that they received less compensation for palliative medicine services than for other areas of practice. The questionnaire inquired specifically about (1) other areas of focused practice, (2) full-practice family medicine and (3) full-practice specialty care (Table 7).

Table 7: Compensation for palliative medicine services in comparison with compensation for other areas of practice

Area of practice of the respondent	Compensation for palliative medicine in comparison with compensation for other areas of practice	Percentage of respondents
Other areas of focused practice (e.g., hospitalists) (*n* = 422)	Equivalent	33%
	More than	4%
	Less than	63%
	Total	**100%**
Full-practice family medicine (*n* = 517)	Equivalent	36%
	More than	13%
	Less than	51%
	Total	**100%**
Full-practice specialty care (*n* = 399)	Equivalent	15%
	More than	1%
	Less than	84%
	Total	**100%**

*Excludes those who abandoned the survey before this question, as well as those who responded **"Don't know"** or who did not respond at all.*

While we did not ask respondents the exact amount that they earn per year, we did ask about remuneration ranges. As shown in Table 8, yearly palliative medicine-related income for PC-FFPs ranges from less than $100,000 per year (16% of respondents) to over $300,000 (4% of respondents). Fewer PM sub/specialists earn less than $100,000 (6%). The majority of respondents in the Others subgroup (67%) earn less than $100,000 per year for their work in palliative medicine; this is not surprising because this subgroup also performs fewer hours of palliative medicine work than the other subgroups.

Table 8: Estimated percentage of income that comes from respondents' palliative practice each year

Question		Palliative care practice, by subgroup			
		PC-FFPs (*n*=127)	PM sub/specialists (*n*=51)	Others (*n*=773)	Total (*n*=951)
Please provide an estimate of income that comes from your palliative practice each year	<$100,000	16%	6%	67%	57%
	$100,001 - $200,000	46%	47%	6%	14%
	$200,001 - $300,000	31%	33%	3%	8%
	$300,001- $400,000	3%	6%	1%	1%
	$400,001 - $500,000	1%	0%	0%	0%
	> $500,000	0%	0%	0%	0%
	Prefer not to answer	3%	6%	19%	16%
	NR	0%	2%	4%	3%
	Total	100%	100%	100%	100%

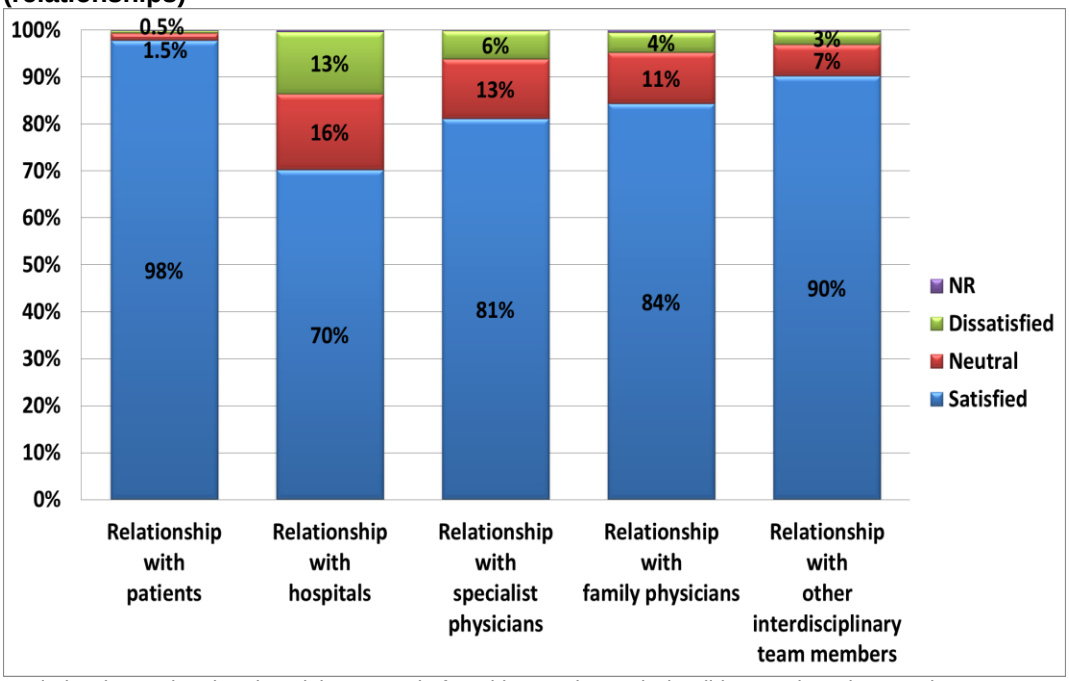
NR = no response; PC-FFP = family physicians with a focused practice in palliative care; PM sub/specialists = specialists/subspecialists in palliative medicine or pediatric palliative medicine.
Excludes those who abandoned the survey before this question.

Detailed information on compensation is reported in the Compensation section of the Data Report.

Satisfaction

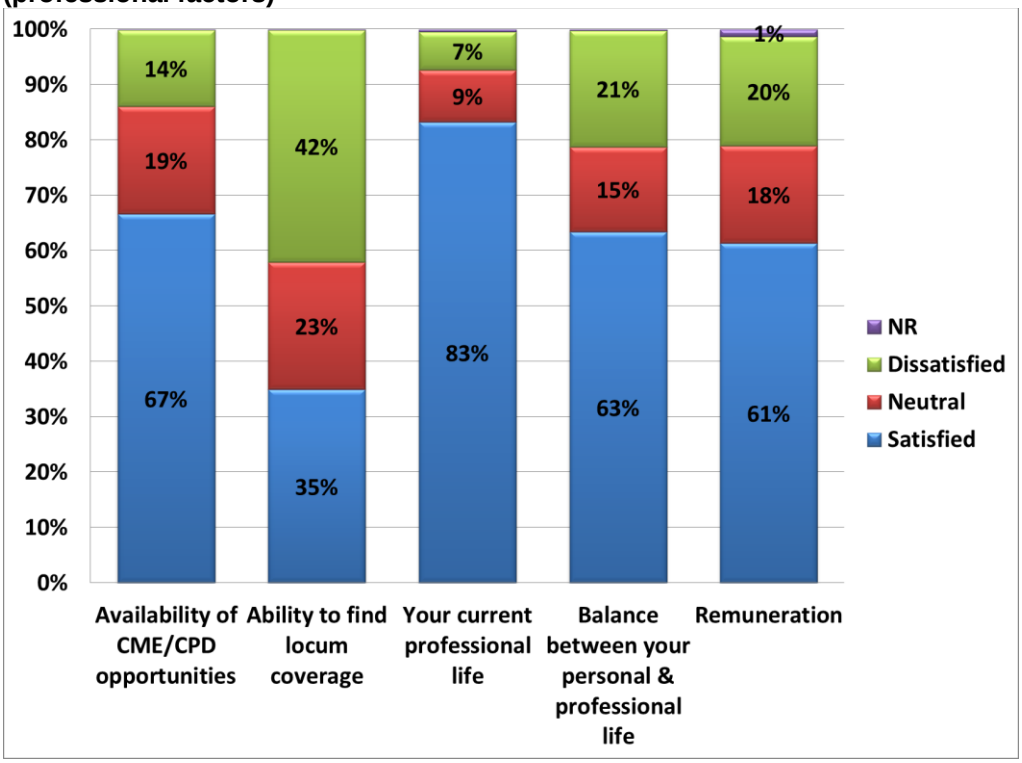
The majority of PMPs surveyed indicated a high degree of satisfaction with most aspects of their palliative medicine practice, especially with their relationships with patients and interdisciplinary team members. The greatest areas of dissatisfaction were as follows: ability to find locum coverage for continuing medical education and continuing professional development (CME/CPD), balance between personal and professional life, and remuneration (Figures 10, 11).

Figure 10: Degree of satisfaction with various aspects of palliative care practice (relationships)



Excludes those who abandoned the survey before this question and who did not reply to the question.
"Satisfied" includes those indicating that they were "very satisfied" and "somewhat satisfied."
"Dissatisfied" includes those indicating that they were "very dissatisfied" and "somewhat dissatisfied."

Figure 11: Degree of satisfaction with various aspects of palliative care practice (professional factors)



Excludes those who abandoned the survey before this question and who did not reply to the question.
"Satisfied" includes those indicating that they were "very satisfied" and "somewhat satisfied."
"Dissatisfied" includes those indicating that they were "very dissatisfied" and "somewhat dissatisfied."

Discussion

The survey yielded interesting results, some of which supported long-held beliefs and others that were surprising. We hope they will stimulate further analysis, discussion and research.

Key Learnings

KEY LEARNING 1: *THE PALLIATIVE MEDICINE WORKFORCE IS COMPRISED OF A WIDE VARITY OF PHYSICIANS IN CANADA, MOST OF WHOM PRACTISE PALLIATIVE MEDICINE AS PART OF THEIR PRIMARY PRACTICE AND NOT AS THE FOCUS OF THEIR WORK.*

Key finding 1.1 Palliative medicine physicians have a variety of clinical backgrounds.

Physicians who identified themselves as palliative medicine sub/specialists (PM sub/specialists) comprised less than 5% of respondents, and those who identified themselves as family physicians with a focused practice in palliative care (PC-FFPs) comprised about 12% of respondents. The majority of the respondents — just over 83% — were a heterogeneous group of other licensed physicians who reported practising palliative medicine as part of their primary practice, such as family physicians, hospitalists and anesthesiologists. In the survey analysis, we defined this subgroup as “Others.” The results of this survey create the foundation for future researchers to further define subgroups of palliative care physicians to accurately identify the spectrum of palliative care provided in Canada and to quantify palliative medicine capacity in this country.

There were marked differences between physicians who focus on palliative medicine and those who practise palliative medicine as part of their primary practice. While PC-FFPs and PM sub/specialists were very similar to each other in their responses throughout the survey, the Others subgroup varied significantly from the PC-FFP and PM sub/specialist subgroups in many areas. These areas include lack of formal preparation for practising palliative care, lack of undergoing any formal assessment process before beginning practice, less involvement in an interdisciplinary team, less academic involvement, less time on call, less involvement with a palliative care unit and significantly fewer hours worked in palliative care. The heterogeneity in the practices of the survey respondents indicates why it is not useful to merely “count” palliative care clinicians.

Additional research may discern whether a more formal educational background in palliative care would enhance the care provided by these “Other” physicians, or if it will remain effective for many physicians to provide palliative care as an auxiliary role in their practice without specialized training.

Similarly, further investigation into the similarities and differences between FFP-PCs and their PM sub/specialist colleagues may help to inform decisions about future training programs for palliative medicine physicians. Such information would also help us learn how to best benefit from the educational and experiential backgrounds of these two subgroups.

Key finding 1.2 The vast majority of palliative medicine physicians work part time in palliative care.

While PC-FFPs and PM sub/specialists (who jointly represented 16% of respondents) reported working an average of 35 hours or more per week in palliative care, the other 84% of

respondents who provide palliative care as part of their primary practice reported working an average of only 7 hours per week in palliative care. If we wish to assess current or future capacity to provide palliative medicine services in Canada, we need to consider not only the number of palliative medicine physicians but also the amount of time that they work in palliative care.

KEY LEARNING 2: *THERE ARE NO MINIMUM STANDARDS IN PLACE TO SUPPORT THE PROVISION OF HIGH-QUALITY PALLIATIVE CARE TO CANADIANS.*

Key Finding 2.1 The standards necessary to practice palliative care as part of comprehensive family practice require revision and strengthening

Palliative care is a core component of the comprehensive family medicine residency program that all future family physicians receive. Family medicine residents' competence in this area is assessed as part of their comprehensive evaluation. However, the data presented here suggests that the role of palliative medicine must be further enhanced to better prepare family physicians to provide high quality palliative care.

The newly introduced Certificate of Added Competence lays a solid groundwork for family physicians who wish to strengthen their skill either as part of a comprehensive practice or in a setting focused on palliative care. Increasing availability of CPD options in palliative medicine is another critical requirement to ensure continuing opportunities for family physicians to maintain and grow their skills in this area.

Further studies and evaluation would help inform the need for further training and assessment for all medical and surgical specialties.

Key finding 2.2 Not all specialists and subspecialists who treat patients living with or dying from advanced illness report having completed training in palliative care.

While some specialties require more advanced skills and knowledge in palliative care, virtually every sub/specialist requires some knowledge and skills in treating patients reaching the end of life and dying from incurable illness, integral to generalism in every discipline.

Yet, responses about training in palliative medicine reveal interesting findings. Of the 51 physicians reporting they were palliative medicine sub/specialists (i.e., palliative care is their area of focused practice or their area of specialty and they are not family physicians), 57% stated they had completed an accredited post-graduate training program in palliative medicine and 39% reported completing other training (Table 4). Of the other sub/specialists who stated they are not palliative medicine sub/specialists but who reported providing some palliative care as part of their practice, the vast majority stated they had not received accredited training in palliative care (Table 4).

To ensure that the Canadian public receives high quality, consistent standards of care, we must establish pan-Canadian standards for entry to practice for sub/specialists who provide highly specialized and complex palliative care. For the other sub/specialists who support acute end of life care, we must ensure that their training and assessment also ensures the required competencies to provide high quality and safe care. Improving the availability of educational resources would also support maintenance of competence among all sub/specialists who provide palliative care.

Key Finding 2.3 The academic aspect of palliative medicine is generally not protected and remunerated.

Palliative Medicine Physicians teach patients, patients' families, other physicians and other health care practitioners. It is therefore not surprising that more than 60% of all physicians reporting palliative care as part of their practice include teaching as part of their professional activities. Despite the strong majority, very few Palliative Medicine Physicians reported any protected academic time for teaching or research (18%). With the increased recognition of the value of palliative care, strengthening the scientific base and knowledge of the discipline is essential. This will increase reliance on an appropriate cadre of academics to further the field and to develop future palliative medicine physicians

KEY LEARNING 3: ACCESS TO PALLIATIVE CARE IN CANADA IS HIGHLY VARIABLE: IT DEPENDS ON WHERE YOU LIVE, HOW OLD YOU ARE AND WHAT YOU ARE DYING FROM.

Key finding 3.1 Patients with a diagnosis other than cancer are unlikely to receive palliative care.

Most patients who receive palliative care are cancer patients. This is not surprising because palliative care started within oncology. However, deaths from non-cancer causes in acute care facilities outnumber those from cancer, and patients with chronic diseases such as congestive heart failure, chronic obstructive pulmonary disease, diabetes, renal failure, severe dementia and severe frailty all have significant symptom burdens that could be amenable to palliative care interventions. In spite of this, 57% of the palliative medicine physicians who responded to our survey reported that fewer than 20% of their palliative patients had a non-cancer diagnosis. It is clear that we need to increase the provision of palliative care services to these populations to meet the needs of all Canadians, regardless of diagnosis.

Key finding 3.2 Access to palliative care for children needs further attention.

Seventy-eight percent of the palliative medicine physicians who responded to the survey reported they do not see patients under the age of 18, and only 50% reported having access to specialized pediatric palliative care services. Most respondents (64% of the non-pediatric palliative medicine physicians) indicated a lack of comfort with palliating children. To ensure that the palliative care needs of Canadians are being met regardless of their age, we need to explore this apparent gap and to ensure that sufficient pediatric palliative care services are available in the future.

Key finding 3.3 Palliative care is delivered differently depending on where you live.

Thirty-five percent of the palliative medicine physicians who responded to the survey from rural and remote areas reported that specialized palliative care teams provide care in their area. Seventy-nine percent of respondents from urban areas reported the same. Home health services, for patients who wish to die at home, were reported to be available by 49% of urban respondents and 30% of rural respondents. The availability of specialty care teams for patients was reported to be highest in Nova Scotia and Alberta. Quebec stands out for being most likely to provide home health services.

KEY LEARNING 4: *TO SECURE A FUTURE PALLIATIVE MEDICINE WORKFORCE, COMPENSATION FOR PALLIATIVE MEDICINE SHOULD RECOGNIZE THE COMPLEXITY OF CARE PROVIDED, AS IT DOES FOR OTHER DISCIPLINES.*

Key finding 4.1 Quality palliative care requires the provision of after-hours and at-home services, but these are not necessarily paid for.

Palliative patients require care 24 hours a day, seven days a week, regardless of whether they are in the hospital or at home. Over two-thirds of the palliative medicine physicians who responded to the survey (68%) reported doing home visits, and at least 74% reported being on call for after-hours care. Not surprisingly, all PM sub/specialists (100%) and virtually all PC-FFPs (91%) reported being on call for after-hours care. Fewer than half (47%) of palliative medicine physicians are reimbursed separately for being on call.

Compensation schemes vary by province and consequently significant variations were reported by physicians from different parts of the country. Regardless of the compensation model, total remuneration for palliative medicine should acknowledge the fullness and complexity of patient care that is required of palliative medicine physicians.

Key finding 4.2 Palliative medicine physicians reported that other areas of medicine are better paid.

This was not validated independently. Addressing real and perceived compensation variations will be particularly important to ensure that the palliative care workforce continues to grow sufficiently to meet the needs of all Canadians.

Where do we go from here?

To ensure that all Canadians have access to quality palliative care from the time when they begin to have symptoms from a chronic or terminal disease to the time of dying, death and bereavement, several foundational pillars must be established.

We must have an adequate workforce. Those physicians must be properly trained and assessed to ensure they are capable of providing the highest standard of care. They must have the resources they need to do the work, including collaboration with allied health professionals in interdisciplinary teams, access to in-hospital beds and services, after-hours schedules and supports, and access to community supports and services. Remuneration for palliative medicine should acknowledge the fullness and complexity of patient care that is required of palliative medicine physicians.

Education of primary care providers has been the focus of palliative care programs in the hope that many family physicians will provide the basic day-to-day symptom management required by patients. This group of physicians needs to be adequately supported, with both resources and compensation, so that it can continue to grow to meet patients' health care needs. At the same time, there must be emphasis on growing the consultant physician role. Universities and medical schools must value the discipline of palliative medicine and must ensure that palliative medicine physicians have the protected time and other resources they need to foster academic growth.

There must be a method or process for ensuring that physicians who practise palliative medicine but do not have formal education in this area meet the minimum standards of knowledge and practice. National standards for practice, including guidance for interdisciplinary care, hours of coverage and so on, need to be developed. Different strategies are needed for rural and urban settings to meet the needs of the population in a realistic yet appropriate way. It is important that the palliative care workforce, including physicians and the other health care professionals who play a role in palliative care, be considered in workforce planning in all jurisdictions.

This is the first comprehensive national survey for palliative medicine in Canada but it should not be the last. We now have baseline data with which to conduct deeper analyses, to develop research questions and to inform policy, practice and workforce planning. We encourage palliative medicine researchers, health care leaders and policy-makers to explore, discuss and debate the findings of this survey.

Acknowledgements

The Human Resources Committee of the CSPCP would like to formally acknowledge and thank the partners for their invaluable support in the creation, dissemination, analysis and reporting of this survey.

Supplementary materials

National Palliative Medicine Survey Data Report. This report provides responses to all of the survey questions. Some analysis tables are included.

Copies of the survey questions are available in English and French.

Materials will be available on all partners' websites, including the website for the Canadian Society of Palliative Care Physicians: http://www.cspcp.ca/information/reports-publications/

References

1. The Way Forward national framework. Available: http://www.hpcintegration.ca/
2. Lorenz KA, Lynn J, Dy SM. Evidence for improving palliative care at the end of life: a systematic review. *Ann Intern Med*. 2008;148:147-59.
3. Ontario Health Technology Advisory Committee End-of-Life Collaborative. Health care for people approaching the end of life: an evidentiary framework. *Ontario Health Technol Assess Ser.* 2014;14(14):1-45.
4. Temel JS, Greer JA, Muzikansky A, et al. Early palliative care for patients with non-small-cell lung cancer. *N Engl J Med*. 2010;363(8):733-42.
5. Klinger CA, Howell D, Marshall D. Resource utilization and cost analysis of home care palliative care service provision. *Palliat Med.* 2013;27(2):115-22.

6. Canadian Hospice Palliative Care Assocaition. Cost-effectiveness of palliative care: a review of the literature. Available: http://hpcintegration.ca/media/24434/TWF-Economics-report-Final.pdf
7. Zimmermann C, Riechelmann R, Krzyzanowska M, et al. Effectiveness of specialized palliative care. A systematic review. *JAMA*. 2008;299(14):1698-1709.
8. Choosing Wisely Canada. Palliative care. Five things physicians and patients should question. 2014 Oct 29. Available: http://www.choosingwiselycanada.org/recommendations/palliative-care/
9. Choosing Wisely Canada. Palliative care: Support at any time during a serious illness. 2014 Oct 29. Available: http://www.choosingwiselycanada.org/materials/palliative-care-support-at-any-time-during-a-serious-illness/
10. Henderson JD. Canadian Society of Palliative Care Physicians — response to "The making of a myth: unreliable data on access to palliative care in Canada." *Health Law Rev.* 2014;22(3):49.