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General Practitioners' Attitudes to Palliative Care : A Regional Perspective

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**General Practitioners' Attitudes to Palliative Care:
A Regional Perspective**

Richelle Lee-Steere

**A Report Submitted in Partial Fulfilment of the
Requirements for the Award of
Bachelor of Arts (Psychology) Honours
Faculty of Community Studies, Education and Social Sciences
Edith Cowan University**

28 October 2002

Abstract

The study explores regional general practitioners' attitudes to palliative care through semi-structured interviewing using a qualitative methodology. Attitudes to palliative care were examined using the general practitioners' accounts of their experiences and perceptions of caring for terminally ill patients. The participants were ten registered general practitioners located within the Greater Bunbury Division of General Practice in the South West of Western Australia. A semi-structured interview schedule containing ten open-ended questions was used to assess regional general practitioners' attitudes to palliative care. Examples of the research questions included: What are regional general practitioners' attitudes to palliative care? What supports are needed by the general practitioners to provide palliative care? The transcripts were analysed using a question-ordered matrix which identified recurring themes within the data. Five themes were identified: namely, quality of life, emotional issues, multidisciplinary collaboration, education and training, and funding issues. Barriers to provision of palliative care by regional general practitioners included the potential for increased specialisation of palliative care in the field of medicine, funding issues, government bureaucracy, and the poor coping strategies of families of terminally ill patients. The supports needed to provide palliative care were identified as the multidisciplinary palliative care team, continuing education and training in pain and symptom control and spiritual issues, and a telephone helpline. Overall, it was shown that regional general practitioners' attitudes to palliative care were positive and the provision of palliative care was fundamental to the role of a regional general practitioner. Results suggested there is a need for the continued expansion and development of regional palliative care services and the continuing education and training of all regional health care professionals in the essentials of palliative care.

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Date Submitted:	28 October 2002

Declaration

I declare that this written assignment is my own work and does not include:

- (i) material from published sources used without proper acknowledgement; or
- (ii) material copied from the work of other students.



Richelle Lee-Steere

3/3/03
Date

To cure, occasionally

To relieve, often

To comfort, always

Anonymous (16th Century)

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- the participants in the study;
- the office of the Greater Bunbury Division of General Practice;
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General Practitioners' Attitudes to Palliative Care: A Regional Perspective

Introduction

Palliative care is recognised as an effective approach to meet the range of needs of people with a terminal illness and their families (Froggatt, 2001; HDWA, 1997). People with a terminal illness and their families who live in regional or rural areas are seen as having particular needs (HDWA, 1997) such as being able to have access to quality palliative care services (Cohen, O'Connor & Blackmore, 2002; DeBellis & Parker, 1998; Dickinson, Sumner & Durand, 1992; Dobratz, 1990; Field, 1998; Field & Taylor, 1998; HDWA, 1997) and having these services adequately funded (Bruera & Suarez-Almazor, 1998; HDWA, 1997). Central to palliative care is the role of the general practitioner (GP) as most of the patient's last year of life will be spent under his or her care (Shipman, Addington-Hall, Barclay, Briggs, Cox, Daniels, & Millar, 2002). As palliative care is only part of the average GP workload, the support of a multidisciplinary palliative care team is vital (Randall & Downie, 1999). Due to increasing workloads and administrative responsibilities, maintenance of skills and expertise can be a challenge (Shipman et al., 2002), particularly in regional and rural areas (Booth & Lawrance, 2001; Strasser, Hays, Kamien & Carson, 2000). Therefore, there is a need to explore the issues of continued expansion and development of regional palliative care services and the continuing education and training of all regional health care professionals in the essentials of palliative care.

Context and Background

Due to an ageing population and increased death rates from long-term chronic diseases, the issues and challenges associated with terminal illness are being experienced by more people in most developed countries (Clark, 1993; Field & Taylor, 1998; HDWA, 1997). This world-wide trend is due to a fall in infant mortality and a decrease in death rates from infectious diseases, diseases of the circulatory system, injury, poisonings, and respiratory diseases (HDWA, 1997). Alongside this, there has been an increase in mortality

from cancer with deaths in Western Australia estimated to have risen by as much as 35% between 1991 and 2001 (Boakes, Gardner, Yuen & Doyle, 2000).

Economic conditions, bureaucracy, and changes in government policy have been found to place pressure on regional and rural GPs since they feel frustrated with circumstances beyond their control, which may result in GPs deciding to leave regional or rural general practice (Porta, Busquet & Jarrod, 1997; Strasser et al., 2000). Nearly 30% of Australians live in regional and rural areas (Clavarino, Lowe, Carmont & Balanda, 2002) yet it has often been reported that it is difficult to get enough GPs to service these areas (Booth & Lawrance, 2001; Clavarino et al., 2002; Rosenblatt, 2002; Strasser et al., 2000). This is partly because regional GPs are disadvantaged in terms of support and services compared to urban GPs (Booth & Lawrance, 2001; Strasser et al., 2000). For example, regional GPs often have to work longer hours, need to have a broader skill base, have more difficulty accessing continuing medical education, and more difficulty obtaining locum relief (Strasser et al., 2000).

In a recent survey of the coverage of cancer patients by designated palliative services in South Australia, it was found that country residents were less likely than residents in metropolitan Adelaide to have received palliative services. However, it was found that the proportion of country residents who received palliative care increased from 47% to 59% due to the implementation of an effective policy that made palliative care services available to country residents (Hunt, Fazekas, Luke & Priest, 2002). Conversely, in the effort to provide access to health care facilities in regional and rural areas, quality of care sometimes becomes the trade-off (Rosenblatt, 2002). It is clear that there is a need for palliative care services in regional and rural areas as the introduction of services to these areas does make a difference, although it must not be at the cost of quality of care.

The Philosophy and Definition of Palliative Care

Palliative care is described as the total care given by a multi-disciplinary team to patients and their families when their disease is no longer responsive to curative treatments (Twycross, 1999; Woodruff, 1999). The origins of the word palliative can be found in the Latin verb *palliare* meaning 'to cloak or shield', and it is from this notion that modern palliative care takes its cue by using treatments whose sole aim is to promote comfort

(Clark & Seymour, 1999; Dunlop & Hockley, 1998; Twycross, 1999). Palliative care is holistic care of the terminally ill and there is an emphasis on control of all symptoms including pain, psychological distress, spiritual and social problems, so that the best quality of life is achieved for patients and their families (Charlton & Smith, 2000; World Health Organisation (WHO) Expert Committee, 1990). Hence, palliative care takes a systemic approach and is patient-centred rather than disease-focused, and responds to the overall needs of the patient (Twycross, 1999).

History of Palliative Care

Early palliative care was multidisciplinary and consisted of clergy, nuns, nurses, family members, and doctors. The first hospice facilities were established by various Catholic Orders in France, Ireland, England, Australia and the United States in the late nineteenth and early twentieth centuries (Woodruff, 1999). In Australia, the Irish Congregation of the Sisters of Charity established the Sacred Heart Hospice in Sydney in 1890 (Clarke & Seymour, 1999). The main concerns of these institutions were primarily religious, moral, and philanthropic; hence there was more emphasis on nursing and spiritual care than medical care (Clarke & Seymour, 1999; Turner & Lickiss, 1997).

It was during the first half of the twentieth century that the discussion of death and dying became socially and medically unacceptable with dying patients seen as medical failures (Woodruff, 1999). This state of affairs was exacerbated by the introduction of chemotherapy for the treatment of cancer in the 1960s along with the expectation that many cancers could be cured (Woodruff, 1999). During the 1970s and 1980s terminal patients had unmet psychological, social, and emotional needs, unrelieved pain and symptoms, and services were poorly co-ordinated (Higginson, 1993). In response to this was an increased awareness of the need for better care for terminally ill patients. Criticism of the hospital system and medical profession included disease-orientated management to the exclusion of psychological, spiritual and family problems, a lack of skilled personnel to provide care in the home environment, and unrelieved pain and a lack of care and attention for patients (Woodruff, 1999). This resulted in the conception of the 'hospice movement' which was dedicated to the improvement of care and support provided for the terminally ill and their families.

The most well-known example of modern multidisciplinary palliative care was the opening of St Christopher's Hospice in London in 1967 by Dr Cicely Saunders which aimed to give patients excellent medical care in tandem with excellent psychological, spiritual, and social care (Kinzel, Askew & Godbole, 1992; Woodruff, 1999). The implementation of this multidisciplinary approach to palliative care included continuity of care for patients after they were discharged from the hospital or palliative care unit. In contrast to previous services, this new approach involved educated and experienced specialist palliative care nurses who worked alongside the patient's GP and a multidisciplinary palliative care team (Woodruff, 1999).

The period after 1967 was one of rapid expansion and diversification in the field of palliative care with the global spread of hospices based on the successful concept of Cicely Saunders (Clark & Seymour, 1999). The success of hospices such as St Christopher's helped establish hospices or hospice wards within general hospitals thus providing many more terminally ill patients with palliative care. The significance of this development was twofold: firstly, palliative care service personnel were back in hospitals working alongside their mainstream medical colleagues; and secondly, through this professional contact the field of palliative care was demonstrated to be a genuine sub-speciality of medicine (Woodruff, 1999).

The year 2002 is the twentieth anniversary of the first home-based palliative care service in Australia (Deverall, Oldham & Cousins, 2002). Twenty years ago in Western Australia the Hospice Palliative Care Service (HPCS) was launched by the Cancer Foundation of Western Australia and the Silver Chain Nursing Association, which serviced the entire Perth metropolitan area by 1984. Total responsibility for the HPCS was given to the Silver Chain in 1985. The Silver Chain continued to provide palliative care services in metropolitan Perth and further expanded to include regional centres (Deverall et al., 2002). Approximately 1,000 terminal cancer patients were referred to these 24 hour services in 1987 (MacAdam & Shaw, 1989).

In the regional area of Bunbury, Western Australia, St John of God Hospital began managing palliative care services in the year 2000. St John of God has a six-bed unit in-patient facility which provides terminal care, symptom control, and respite. Home care is also provided and funding received for private and public patients. As well as caring for

cancer patients, St John of God cares for people with diseases such as non-malignant multiple sclerosis and end-stage cardiac and renal patients (R. Grapes, personal communication, October 24, 2002). From July to December 2001, 45 patients were admitted to palliative care, and from January to June 2002, 57 patients were (St John of God Hospital Oracare Patient Data, 2002). This demonstrates a growing need for palliative care services in the regional Bunbury area.

Psychosocial and Spiritual Issues

Optimising the quality of life of terminally ill patients is the primary goal of palliative care (Richards & Ramirez, 1997; Twycross, 1999). Quality of life in palliative care is concerned with the patient's subjective satisfaction with life, and a good quality of life is apparent when a patient's aspirations are matched by their present experience (Twycross, 1999). This is best achieved through the control of physical symptoms and attending to the psychological, social, and spiritual needs of the patient (Daaleman & VandeCreek, 2000; Richards & Ramirez, 1997).

In Western countries today, management of pain is often thought to be inadequate with approximately 30-50% of terminally ill patients estimated to experience severe pain which could be successfully relieved in 80-90% of cases (Bauwens, Distelmans, Storme & Kaufman, 2001). The results of a study on GPs' knowledge of patients' symptoms found that GPs were likely to miss symptoms viewed as difficult to control and symptoms that rarely occurred. GPs and district nurses differed in the symptoms they felt confident in controlling, and it was concluded that teamwork between the two professions about pain and symptom control would enhance quality of life for terminally ill patients (Grande, Barclay & Todd, 1997).

All human beings possess their own unique spirituality whether they are religious or not and it is the basis for an individual's attitudes, beliefs, actions, and values (Woodruff, 1999). Spirituality is pertinent to palliative care because it is about making sense of human life and the nature of existence and as palliative care is formally committed to a holistic approach, the question of how to deal with spiritual issues often arises (Byrne, 2002; Daaleman & VandeCreek, 2000; Mulder & Gregory, 2000; Walter, 2002; Wright, 2002). Spirituality has a wide range of interpretations, so predictably the delivery of spiritual care

is diverse (Byrne, 2002). To communicate information and meaning, we use language, and it has been proposed that there is a language of spirituality that caregivers may not necessarily be conscious of, which includes factors such as faith, hope, love and compassion (Byrne, 2002). Little research has been done on spiritual care; however Wright (2002) interviewed 16 people involved in palliative care and concluded that quality of care for the patient was better if caregivers had first addressed their own spirituality and were willing to take time to 'be there' for the patient. In order to optimise the delivery of high quality care to terminally ill patients, it was also concluded that more staff training and an integrated approach to spirituality would be beneficial among members of a palliative care team (Wright, 2002).

The Palliative Care Team

The multidisciplinary palliative care team is a central tenet to the philosophy of palliative care as the skills and knowledge of a variety of health care professionals is essential if the aims of palliative care are to be met (Randall & Downie, 1999). Teamwork in palliative care aims to successfully maximise the terminal patient's quality of life until death (Hull, Ellis & Sargent, 1989; Richards & Ramirez, 1997). Palliative care teams comprise medical, nursing, administrative staff and other professionals such as clinical psychologists, social workers, psychiatrists, physiotherapists and occupational therapists. The team may also include chaplains, relatives of the dying patient, and volunteers (Randall & Downie, 1999). As there is an overlap of roles, communication is of paramount importance when working in a team, and team members have found that regular team meetings are useful as a forum for coordination and discussion about issues that arise when working in groups such as patient problems, aspects of team function, and stress and conflict management (Dunlop & Hockley, 1998; Twycross, 1999). Overall, teamwork is essential in palliative care and in any given case the GP, nurse, therapist, or volunteer each has a very important role (Allbrook, 1990). Interestingly, when conflict does occur, it has mainly been found to occur between GPs and registered nurses with regard to issues such as pain and analgesia management (DeBellis & Parker, 1998).

The Role of the GP in the Palliative Care Team

The role of the GP in the palliative care team has been summarised by Buchanan, Millership, Zalcberg, Milne, Zimet and Haines (1990). Firstly, there is a need for GPs to perform a routine palliative medical assessment to ascertain the main symptom problems, what symptoms will arise, and whether a psychological syndrome is present. Secondly, they need to control symptoms such as physical distress. They also need to address symptoms of psychological distress such as depression and anxiety, as other supportive measures will be hard to implement if this is not taken care of. Thirdly, GPs need to use medical counselling to keep patients and families informed of treatment procedures and enhance patient and family control over daily issues such as control of analgesia. Fourthly, GPs should assume team leadership as they have the best overview of the natural history of the disease, inclusive of a good knowledge of palliative care alternatives.

GPs are usually the leaders and principal decision-makers of the palliative care team, however flexibility in adjusting to the role demands of the situation mean, for example, that nurses may become more important than doctors for dying patients (Hull et al., 1989). GPs usually view themselves as part of a team of equal carers with their role consisting of co-ordinating care such as giving approval for treatment changes recommended to them by nurses and other team members (Field, 1998). Working with medical colleagues from other disciplines and other people from different academic backgrounds has been shown to be a rewarding and stimulating experience for GPs (Allbrook, 1991).

Rather than attempt to manage everything by themselves, GPs have indicated that they are willing to share or hand over the more holistic aspects of terminal care such as spiritual, social, family, and bereavement care to other team members who may be more highly skilled in these areas (Hunt, Radford, Maddocks, Dunsmore & Badcock, 1990). In general, GPs believe that a multidisciplinary team approach to palliative care is in their best interests as it helps obtain the best result for the patient by bringing together the skills and expertise needed to address the full range of their physical, spiritual, and psychosocial needs (HDWA, 1997; Randall & Downie, 1999). Therefore, since GPs play a central role in caring for terminally ill patients, palliative care teams cannot function optimally without effective medical participation and direction (Gunz 1989; Shipman et al., 2002).

The relationship between GPs, hospital consultants, and community nurses when caring for terminal patients was examined by Cartwright (1991). The results showed that 86% of GPs liked to use nursing care where possible and preferred nurses to establish contact with terminally ill patients prior to them becoming extremely ill in order to build up a relationship with them. It was also found that GPs would like to see some changes such as more staff and more night cover. The nurses were of the opinion that the GPs did not ask for nursing help early enough for terminal patients, however GPs may have believed that the nursing services were overstretched. GPs were also found to be less enthusiastic than community nurses or hospital consultants about specialist medical or palliative care services, although this was not always the case as it depended upon whether they had experience of those services. The opinion expressed by the nursing staff about GPs was that the relationship was good if the GPs had a positive attitude to terminal care and that the relationship was not good if they held a negative attitude to terminal care (Cartwright, 1991).

There are many reasons for GPs not providing palliative care. These include emotional issues and stress, emotional issues and communication/family, specialist services, cost-effectiveness, continuing medical education and training, and attitudes.

Emotional Issues and Stress

GPs' own attitudes, fears, and vulnerabilities, such as the need for accomplishment, may also hinder the psychological care of their patients often resulting in avoidance and distancing tactics (Dunlop & Hockley, 1998; Kenyon, 1995). One source of stress for GPs would appear to be emotional involvement with patients (Woodruff, 1999), and concerns about exposing themselves to painful emotions (Kenyon, 1995). In particular, young doctors experience difficulty in this area as they are still developing their own personal views about death and dying (Field & James, 1993).

Young terminal patients and their relatives have been identified as a source of stress for GPs as they generate closer and more emotionally laden contact with them and since GPs may identify with a younger generation, it raises the possibility of one's own, or one's children's, death and bereavement in a directly personal way that elderly patients do not (Field & James, 1993). Other stressful situations for GPs include making decisions about

whether to continue with, or stop treatment of patients who are about to die (Dunlop & Hockley, 1998). This is exacerbated if GPs feel they have a lack of knowledge of symptom control (Grande et al., 1997). Furthermore, GPs may experience stress, anger and frustration when, despite treatment, patients inexorably continue to deteriorate as disease relapse and death can be seen as failures now that medical technology can do much to preserve life (Dunlop & Hockley, 1998).

Emotional Issues and Communication/Family

Clear communication is an essential component of palliative care and good communication between GPs and their patients can improve health outcomes inclusive of symptom relief, functioning, and emotional health as well as enhancing patient and family satisfaction (Bradley, Cicchetti, Fried, Rousseau, Johnson-Hurzeler, Kasl & Horwitz, 2000). Understanding and working with the families of the terminally ill is a very important aspect of palliative care for GPs as patients' quality of life is strongly influenced by their relationship with family members (Allbrook, 1991; MacAdam, 1988; Woodruff, 1999). However, many GPs are reluctant to communicate about the nature of illness with terminally ill patients, even though it has been found that many terminal patients are eager to talk about their situation in order to ease their sense of apprehension and isolation (Clark & Seymour, 1999; Hanratty & Higginson, 1994; Todd & Still, 1993). This may result from GPs fear of saying the wrong thing or having poor communication skills (Hanratty & Higginson, 1994).

A major source of difficulty surrounding the disclosure and prognosis of a person's terminal illness by GPs has been found to be the relatives of the terminally ill person, who may believe that information should be withheld from the patient, thus causing great confusion and clashes about what information should be given to whom (Randall & Downie, 1999). Closely identifying with terminally ill patients or their family members also has the potential to raise the possibility of one's own death in a directly personal way (Field & James, 1993).

Specialist Services

The difference between a GP and a specialist is that the GP concentrates on the overall history and current situation of the patient within a medical, psychological and social context, and the specialist develops expertise in one defined area such as palliative care (Shipman et al., 2002). Some GPs are appreciative of specialist services as they improve their ability to provide palliative care (Hanratty, 2000; Shipman et al., 2002; Virik & Glare, 2002). In order to provide a good quality of life for terminal patients, continuity of care allows patients to develop the attention and friendship of one doctor with whom they trust and feel comfortable sharing their hopes and fears (Smith, Nicol, Devereux & Cornbleet, 1999). As continuity of care is viewed by GPs as being integral to general practice, specialist services have also been identified as a barrier to GPs' participation in palliative care as some GPs are concerned about surrendering patient care to the specialists (Field, 1998).

In Australia, specialist palliative care services have been going through a period of expansion and development with the introduction of a Palliative Medicine Liaison Consultation Service (Virik & Glare, 2002). This service has been particularly useful for regional and rural GPs as such a specialist telephone information service has been found to be invaluable for information about topics such as pain and symptom control (Gloth & Schwartz, 2000; Schroder & Seely, 1998).

A study on the interaction of GPs and specialists in palliative care was conducted by Shipman et al. (2002) by interviewing 63 inner-city, urban, and rural English GPs. The results showed that when channels of communication were good, the GPs' attitudes were positive as they felt well-supported by the specialists. The rural GPs noted that information updates and telephone contact were excellent, but distance and access to specialists was a concern. GPs that rarely used specialist services had predominantly negative attitudes. This was due to GPs considering their expertise sufficient, they expected or experienced delays in accessing support, they feared losing control over patient care, breaking the continuity of care, poor communication over a patient or disagreement about medication, or they had little knowledge of available services. Therefore, in accordance with Field (1998), it would appear that GPs would like to be able to call upon specialist services as required but do not want to totally surrender care of the terminally ill to the specialists.

Cost-Effectiveness

In many countries health care budgets are decreasing and in order to justify the allocation of resources to palliative care, cost-effectiveness needs to be evaluated (Bruera & Suarez-Almazor, 1998; Higginson, 1993; Richards & Ramirez, 1997). This has been identified as a barrier to GPs participation in palliative care as forced choices have to be made between different services and treatments for palliative care patients, which may not necessarily be in the best interests of the patient (Richards & Ramirez, 1997). GPs may not embrace palliative care because of demands on their time (Kenyon, 1995). The impact of a regional palliative care programme on the cost of palliative care delivery in Edmonton, Canada found that the implementation of an integrated palliative care programme reduced the overall cost of care. The increased funding for the programme was offset by the reduction in use of acute care facilities by palliative care patients (Bruera, Neumann, Gagnon, Brenneis, Quan & Hanson, 2000). An evaluation of systematic reviews of palliative care services found that overall, palliative care services increased patient satisfaction, improved pain and symptom control, and produced evidence of cost savings in the last month of life (Goodwin, Higginson, Edwards & Finlay, 2002).

Issues of cost-effectiveness that are particular to regional and rural areas of Australia include a lack of local specialised care, and travel and accommodation costs, which can significantly disrupt the patient's family life (Clavarino et al., 2002; Shipman et al., 2002). It has been reported that in order to ensure basic services in regional and rural areas, quality of care may be compromised (Rosenblatt, 2002). Resources, costs, time, and staff shortages are also considered to be potential barriers to GPs, especially in areas such as continuing education (Sellick, Charles, Dagsvik & Keley, 1996).

Continuing Medical Education and Training

Urgent and complex responses are often required from GPs for the terminally ill and throughout the literature there is evidence of a lack of continuing medical education (CME) and training for GPs in palliative care (Boakes et al., 2000; Brenneis & Bruera, 1998; Charlton & Smith, 2000; Gott, Ahmedzai & Wood, 2001; Llamas, Llamas, Pickhaver & Piller, 2001; Shipman, Addington-Hall, Barclay, Briggs, Cox, Daniels & Millar, 2001). CME in pain and symptom control, psychosocial needs, and bereavement counselling are

consistently cited as areas of educational deficit for GPs (Boakes et al., 2000; Field, 1998; Hall, Hupe & Scott, 1998; Shipman et al., 2001). However, pain and symptom control consistently emerges as the most challenging area for GPs in the care of the dying (Brenneis & Bruera, 1998; Hall et al., 1998; Shvartzman & Singer, 1998) as it requires the GP to have an understanding of pharmacological, surgical, and radiological techniques in order to make the patient more comfortable (Yuen, Barrington, Headford, McNulty & Smith, 1998). A lack of necessary clinical knowledge has been cited by Shvartzman and Singer (1998), which in turn is due to a lack of training in medical and graduate school curricula.

Often it is only GPs who have an interest in palliative care who make the effort to attend lectures and seminars to further their learning about communicating with terminal patients and increase their knowledge of symptom control (Dunlop & Hockley, 1998). The education of general practitioners and care workers in palliative care is just managing to keep up with the demand and the provision of palliative care in nursing homes is often at the expense of something else (DeBellis & Parker, 1998). In Western Australia, CME for GPs has been emphasised in Perth through three month courses in palliative medicine available as a unit toward the master of primary health care degree (Lickiss, 1993). It was suggested by Block (2002) that improvement of further education for GPs in palliative care would depend on a successful definition and refinement of attitudes, specialised knowledge, and skills in palliative medicine.

A study conducted by Llamas et al. (2001) examined staff perspectives on palliative care needs at a major teaching hospital in Australia which at the time lacked a designated palliative care service. Results showed that only 24% of respondents reported having had any formalised palliative care education and that 93% of staff felt that they needed to increase their skills and knowledge in the field of palliative care. In order to improve GPs palliative care skills and knowledge, Boakes et al. (2000) used an experiential approach in GP education in palliative care in Western Australia. The program was shown to increase GPs confidence and enhance their knowledge and skills thus altering their practice behaviour in a beneficial way for patients, relatives and staff. These positive changes were maintained for at least six months after follow-up. This study demonstrated that further

education for GPs in the field of palliative care improves the overall quality of care for the palliative care patient.

In different parts of the world, psychosocial and environmental factors can differ significantly thus influencing the set of attitudes and approach to palliative care from place to place (Shvartzman & Singer, 1998; Vogel, 1992). For example, a study conducted by Shipman et al. (2001) compared 1061 inner-city, urban and rural GPs in England about their educational preferences in palliative care topics using postal questionnaires. It was found that rural GPs were less likely than their inner-city and urban counterparts to want further education in pain and symptom control and bereavement counselling. However, a study of rural general practice in Britain by Herd (1990) showed that symptom control was the reason most GPs referred patients for hospital admission.

In particular, rural and regional GPs have reported a strong need for further education in skills such as pain and symptom control and bereavement counselling (Boakes et al., 2000). The lack of opportunity to access CME and training has emerged as a major problem affecting the recruitment and retention of regional and rural GPs (Booth & Lawrance, 2001; Lickiss, 1989; Strasser et al. 2000). Findings from a study in South Australia by the South Australian Health Commission in the early 1990s showed that 15.6% of male GPs and 33% of female GPs felt inadequately trained for regional and rural practice. Difficulty accessing CME was reported by one quarter of the GPs, while almost 38% of those undertaking CME reported finding it difficult to obtain. Nearly 20% stated that access to CME was an issue affecting the continuation of regional and rural practice (Booth & Lawrance, 2001). These findings have been found to concur with previous research five years earlier in Western Australia where 27% of regional and rural GPs had difficulty accessing CME (Booth & Lawrance, 2001). Therefore, there is a need for CME and training for regional and rural GPs in order to recruit and retain GPs in these areas so that good quality of care can be provided.

Attitudes

Negative attitudes may be one reason for GPs not providing palliative care. GPs' attitudes to palliative care is important because as providers of medical care for the dying, they are the key to the maintenance of quality and continuity of care for terminally ill

patients and their families before, during, and after the illness (Burge, McIntyre, Kaufman, Cummings, Frager & Pollett, 2000). The importance of studying GPs' attitudes to palliative care is demonstrated in a study by Charlton (1991), which found that 50% of terminally ill patients preferred to be managed by their GP, with only 6% of the patients requesting a hospital doctor, and this trend increased with the age of the patient. Previous research on GPs' attitudes to palliative care has indicated that such attitudes are complex and can change over time and with experience (Bradley et al., 2000). Variation in GPs' attitudes to palliative care may arise because their individually different training and personal life experiences will have contributed to the formation of their attitudes, however they ought to share the basic goals of; firstly, a commitment of compassionate care to the patient, and secondly, a belief in an appropriate, painless and peaceful death for the patient (Vogel, 1992).

There has been a paucity of research on the views and attitudes of GPs themselves towards their care of the terminally ill and their families (Field, 1998), and the research findings are equivocal or ambiguous. A study on the attitudes and views of 87 physicians and 64 nurses in Spain towards cancer patients dying at home was conducted by Porta et al. (1997). The results confirm the findings of Bruera, Neumann, Mazzocato, Stiefel and Sala (2000) showing that attitudes were significantly influenced by geographic location. It was also found by Porta et al. (1997) that attitudes were clearly influenced by age and sex. They also had a higher response rate from rural areas than urban areas. A significant finding of the study was that physicians and nurses working in a rural environment were much happier with the support given to the family as opposed to urban physicians and nurses. These findings are in direct contrast geographically with similar studies conducted in Australia (Wakefield, Beilby & Ashby, 1993) and England (Herd, 1990) where rural GPs reported having more problems dealing with the emotional distress of families than physicians in urban areas.

Potential reasons contributing to Australian rural GPs' attitudes to emotional issues with family members could be that they carry a heavier burden of care due to lack of support staff, they are more involved emotionally in an intimate setting with the patient and family, they suffer from professional isolation, they have a lack of time off and have rare debriefing opportunities. Other reasons could be the physical distance from sources of

support for the family, and the fact that resolution of the family's grief could be more difficult in the rural situation (Wakefield et al., 1993).

Attitude Theory

In order to enhance positive attitudes we need to know what underpins attitudes. Attitude theory provides a useful framework to explore attitudes. Historically, Gordon Allport (1935) gave formal recognition to the importance of attitudes and viewed the concept of attitudes as "the most distinctive and indispensable concept in contemporary American social psychology" (Himmelfarb & Eagly, 1974). Despite its long history of research, a simple definition of attitudes is elusive as there is no commonly agreed-upon definition (Olson & Zanna, 1993). Attitudes have been defined in terms of affect, cognition, and behavioural predispositions, but they are primarily defined in an evaluative sense where attitudes are learned predispositions to respond to people, objects, or ideas in a favourable or unfavourable manner (Eagly & Chaiken, 1993; Eagly, Mladinic & Otto, 1994; Feldman, 1995; Olson & Zanna, 1993; Zanna & Rempel, 1988). Therefore, responses from people that express evaluation are thought to reveal their attitudes.

Evaluative cognitive responses are thoughts or ideas about the attitude object and are often conceptualised as *beliefs*. Evaluative affective responses consist of emotions, feelings, and moods, which can be conceptualised as belonging on a dimension of *meaning*. Evaluative behavioural responses consist of the overt actions of people in relation to an attitude object and can be regarded as encompassing *intentions* (Eagly & Chaiken, 1993). This information on attitudes is necessary to bring about positive changes in attitudes in order to overcome the barriers to effective palliative care by regional GPs. Attitude theory is useful in exploring the issues involved such as the need for further evaluation and clarification of regional GPs' attitudes to palliative care, with regard to their beliefs, emotions, and behaviour.

Hence, the research questions for this study are:

- 1 What are regional GPs attitudes to palliative care?
- 2 What factors contribute to the formation of regional GPs attitudes to palliative care?
- 3 What are the barriers to the provision of palliative care?
- 4 What supports are needed by GPs to provide palliative care?

Method

Design

An exploratory in-depth qualitative design was adopted. In-depth interviews were used to answer the research questions relating to regional GPs' attitudes to palliative care. Qualitative research interviews are a flexible and interactive method that allows an exploration of emotional and personal matters, which are salient in attitudinal research (Zanna & Rempel, 1988).

As palliative care is essentially a holistic approach encompassing physical, emotional, social, and spiritual needs, qualitative research in the form of in-depth interviews is an appropriate and sympathetic tool ideally suited for research in this domain (Clark, 1997; Wilkie, 1997). Furthermore, qualitative research interviews allow questions that facilitate the exploration of an issue as well as the emotional aspects of the issue. They are a suitable method of research when a sensitive topic such as palliative care is to be studied (Wilkie, 1997).

In the quest for rigour in qualitative research, it is important for the researcher to develop an awareness of his/her own objectivity as part of the research process as well as being aware of the perspective of individual participants (Coakes, 1995). Noting personal reflections and reactions to the data enables the researcher to be more objective about ideas, insights, understandings, concerns, prejudices, assumptions, questions, and thoughts on the quality of the data and the relationship with participants (Miles & Huberman, 1994).

In designing and conducting qualitative studies in relation to end-of-life issues the highest standards of ethical engagement are necessary to avoid intersubjectivity (Clark, 1997). It has been recommended by Clark (1997) that qualitative research should follow a set of procedures that are rigorous and searching in design and execution. To ensure the maintenance of rigour in qualitative data, Miles and Huberman (1994) have suggested that an audit trail be implemented inclusive of comprehensive hand written notes, the keeping of a reflective diary, and a process of authentication by member checking, such as disclosing as much information as possible to a group of three people, and peer debriefing.

considerations, feelings about available locally based services and support, and continuing education for GPs in the field of palliative care.

Procedure

Appointments were made with the practice managers of medical practices in the GBDGP in order to outline the proposed study and seek their assistance in recruiting the GPs to participate in the research. After ten days, the practice managers were contacted by telephone and times were organised in the following three weeks to interview the GPs that had agreed to participate in the research.

Prior to the commencement of each interview, participants were informed about the purpose of their participation, the nature of the inquiry, and the intended use of the information. They were guaranteed that confidentiality and anonymity would be maintained at all times and that they could decline to answer any question and withdraw from the study at any stage of the proceedings. The participants then read the information sheet (Appendix B), and signed and dated the consent form (Appendix C).

Interviews were conducted in the consulting rooms of the GPs. All interviews were tape-recorded and ranged from 30 minutes to one hour and 15 minutes in duration. Demographic information such as the participant's age, sex, place of training, and amount of time practising as a GP was collected.

After completion of each interview, participants were debriefed, thanked for their participation and given a small gift of chocolates. The contact telephone number of the researcher was provided in case there were any further issues they wished to discuss. They were informed that when the research was completed, a report would be made available through the GBDGP. At the conclusion of each of the ten interviews, note-taking was completed on each participant's interview sheet.

Data Analysis

In order to ensure accurate and authentic records for analysis, the participants' data was transcribed verbatim. Qualitative analysis allows for the collapsing of large quantities of data into smaller, more manageable units in order to assist in the search for the key

factors that emerge relating to experiences, awareness, intentions, appreciation and impressions of the participant (Hase & Meyers, 1988; Miles & Huberman, 1994).

The transcripts of the interviews were summarised in a question-ordered matrix (Appendix D) in order to identify recurring themes within the data in a systematic and logical manner (Miles & Huberman, 1994). The data matrix was constructed by listing the questions from one to ten and rating the GP's response to each question across in a columnar display. As themes relevant to the research focus were identified in the data, a list was made of the connections between the themes in order to aid the refinement process. This entailed returning to the transcripts and ensuring that each word or phrase matched with the assigned theme. Subsequently, a number of potential themes and sub-themes emerged. After a process of verification and re-definition, a master-list of themes was produced containing several sub-categories.

Rigour was provided by an independent co-analyst cross-checking the list of themes in the data matrix and matching the coding decisions that had been made by the researcher. Through consultation with the co-analyst, several of the initial themes were merged. Five themes were derived from the data, each containing several sub-categories.

In order to increase authenticity, and in accordance with Miles and Huberman (1994), the audit trail was increased. Firstly, the hand-written notes on the interview sheets were compared with the transcribed data in order to help ensure accuracy. Secondly, the researcher disclosed as much information as possible about the research to a peer group consisting of three people. This member checking was instrumental in consolidating the themes as well as providing different perspectives on the data.

Findings and Interpretations

The aim of this study was to explore regional GPs' attitudes to palliative care through semi-structured interviewing using a qualitative methodology. Attitudes to palliative care were explored using the GPs' accounts of their experiences and perceptions of caring for terminally ill patients. Five themes emerged from the research that were related to regional GPs' attitudes to palliative care. Table 1 contains the five major relational themes identified from the analysis of the participants' responses: quality of life, emotional issues, multidisciplinary collaboration, education and training, and funding

issues. The related sub-categories are also included in Table 1. While discussed separately, these themes were not mutually exclusive and overlapped frequently.

Table 1

Regional General Practitioners' Attitudes to Palliative Care Relational Themes

Main themes	Sub-categories
Quality of life	Pain relief Spirituality Continuity of care Specialist Services
Emotional issues	Family interaction Awareness of mortality Young terminal patients Emotional awareness
Multidisciplinary collaboration	Good supportive team Administrative changes Changes to nursing staff
Education and training	Treatment change updates Telephone helpline
Funding issues	

Quality of Life

Regional GPs' perceptions of quality of life were contained within four context-related categories. These categories were directly attributed to the GPs in terms of pain relief, spirituality, continuity of care, and specialist services. Quality of life was found to apply to all facets of palliative care and was a recurring theme throughout the study. This was demonstrated by the beliefs of one GP:

... I believe that good palliative care can make a huge difference to a person's last illness and their experience and preparation for death, and particularly also to the

family people who will be grieving afterwards. Their experience of the person's illness is very important as part of the grieving process. I think that a well-managed palliative care experience can make a huge difference.

Quality of life was frequently referred to in the literature as it relates to a person's satisfaction with life, and one of the goals of palliative care is to provide the best possible quality of life for the patient and family (Richards & Ramirez, 1997; Twycross, 1999).

Pain Relief

The majority of participants emphasised that being in control of pain relief was critical in achieving quality of life. Overall, the participants believed that pain relief was very much their responsibility and was integral to terminal patients' quality of life. For example, one GP stated that the only person who kept him awake to any extent was a patient whose cancer pain was out of control:

I really couldn't get his pain under control and it really bothered me. He was saying things like "Kill me doctor, you know, do me in I've had enough of this. You've got to do something about this." He lived for three or four days in quite severe pain and I went and asked for advice from a lot of people and we really could not adequately get it under control in my opinion.

Pain and symptom control was consistently referred to throughout the literature as the most challenging area for GPs in the care of terminally ill patients (Brenneis & Bruera, 1998; Hall, Hupe & Scott, 1998; Shvartzman & Singer, 1998). Should pain and symptom control not be satisfactorily addressed, other supportive measures for the patient and family would be difficult to implement (Buchanan, Millership, Zalcberg, Milne, Zimet & Haines, 1990). When GPs thought they were lacking in knowledge of pain and symptom control, they were found to experience feelings of stress, anger, frustration and a sense of helplessness (Dunlop & Hockley, 1998; Grande, Barclay & Todd, 1997).

Spirituality

The participants often mentioned that palliative care also included caring in areas other than the purely physical. Not all the GPs in the current study felt comfortable with the spiritual and holistic side of palliative care, and further education and training in these areas was perceived to be an area of interest. In the words of one GP:

... you tend to back off a bit ... as far as areas I would like personally addressed, perhaps more education in terms of counselling patients or even families in terms of spirituality and beliefs and acceptance, and working on that. Possibly education about acceptance in a philosophical kind of sense ... the psychological aspects of it.

The purpose and meaning of a person's life is encompassed in spirituality and most terminally ill patients will experience spiritual or existential distress (Woodruff, 1999). It was suggested that GPs are willing to share or hand over the more holistic aspects of terminal care such as spiritual, social, family, and bereavement care to other palliative care team members who may be more highly skilled in these areas (Hunt, Radford, Maddocks, Dunsmore & Badcock, 1990). In order to optimise the delivery of high quality care to terminally ill patients, it was recommended that more staff training and an integrated approach to spirituality be adopted among members of a palliative care team (Wright, 2002).

Continuity of Care

The participants were of the opinion that the role of the GP was one that covered the spectrum of the disease and in some cases over a person's lifetime. The GPs indicated that in palliative care they were more comfortable dealing with patients with whom they had prior involvement with and in some cases over a very long period of time:

... I suppose I would have one palliative care patient per month maybe ... they are usually people I have known for fifteen or twenty years. You end up often diagnosing it and then seeing it through to the end.

It's unusual to be looking after a dying patient and not have looked after them for some of their lifetime and know some of their medical history, so looking after a dying patient there has generally been a lot of contact beforehand and that's an issue.

This confirms the experience of one GP:

I think one issue is the patients coming from out-of-town ... that's quite difficult I think to pick up a palliative care patient ... they're always complex medically and socially and you don't have the background ... it can be a really quite complex and difficult situation.

Continuity of care was found throughout the literature to be essential in the provision of a good quality of life for terminal patients as they needed the attention and friendship of one doctor they trusted and with whom they felt comfortable sharing their hopes and fears (Smith, Nicol, Devereux & Cornbleet, 1999). Regional and rural GPs have been found to be more emotionally involved with patients and their families than their urban counterparts as they interact with them on a regular basis in a more intimate setting (Wakefield, Beilby & Ashby, 1993).

Specialist Services

Participants firmly believed that caring for people from birth until death was essential in regional general practice, as was stated by one GP:

It was the day after September 11th when one of my patients died in palliative care and I delivered a baby that day as well. I remember because I made the comment that I would have preferred to be the lady in palliative care rather than the baby that was born because of the world that this baby was coming into. I mean that's what general practice is. You look after people from the start until the end and I think that's why general practice should be the mainstay of palliative care.

Specialists develop expertise in one defined area of medicine, such as palliative care, whereas GPs encompass the patient's current situation and their entire history within a medical, psychological, and social context (Shipman, Addington-Hall, Barclay, Briggs, Cox, Daniels & Millar, 2002). As providers of medical care for the dying, it was often mentioned in the literature that GPs are the key to the maintenance of quality and continuity of care for terminally ill patients and their families before, during, and after the illness (Burge, McIntyre, Kaufman, Cummings, Frager & Pollett, 2000).

The participants were thankful to have specialist support and acknowledged it as such:

I'm not too proud to ask for help with particularly difficult situations ... some are very difficult and I have to pass things over to someone who knows more than I do ... the more really high-tech stuff such as nerve blocks and things is definitely in the realm of the specialists.

As noted in the literature, GPs are appreciative of specialist services as they improve their ability to provide palliative care (Shipman et al., 2002; Virik & Glare, 2002).

Whilst appreciating specialist services, the fact that future palliative care might become a specialist-type service was of concern to the participants:

I think there is a tendency like in most specialities to get the GP to cease being involved and I think it'd be a bit of a sad case although we probably don't do the best job technically. I think it is important we have that continuity for the family's sake. I think that's one barrier ... perhaps the idea that there needs to be a specialist type service. I'm sure a specialist can do a really great job in selected cases but I really do hope that GPs do maintain overall control of it and only use specialists when they need to. It's not really so much a problem now but it often happens like that in any specialist branch in medicine that GPs tend to be pushed out with the availability of specialists.

Palliative care is not just for the patient, it is for the family as well. Generally, when you are looking after someone, you are also looking after the family and provide that ongoing support afterwards which a specialist palliative care service really wouldn't be able to do as effectively as a family doctor.

As continuity of care, and hence quality of life, is viewed by GPs as being integral to general practice, some GPs are concerned about surrendering patient care to the specialists (Field, 1998). This concern appeared to have been further exacerbated in Australia as specialist services for palliative care have been going through a period of expansion and development (Virik & Glare, 2002).

In summary, the results showed that quality of life was a recurring theme throughout the study as it was found to apply to all facets of palliative care. The participants believed that pain relief was very much their responsibility and was integral to terminal patients' quality of life. If pain relief was not addressed adequately, the participants were of the opinion that other supportive measures for the patient and family would be difficult to implement. A key to palliative care for the participants was to acknowledge the point at which no further cure could be provided and subsequently change their focus to one of assisting patients with comfort until death.

Not all the GPs in the current study felt comfortable with the spiritual and holistic side of palliative care. The participants believed that the role of the GP was one that covered the spectrum of the disease, and in some cases, this was over a person's lifetime. The participants indicated that in palliative care they were more comfortable dealing with patients with whom they had prior involvement and they firmly believed that caring for people from birth until death was essential in regional general practice. Whilst appreciating specialist services, the fact that future palliative care might become a specialist-type service was cause for concern as the participants believed that continuity of care for terminally ill patients and their families was very important before, during, and after the illness.

Emotional Issues

Regional GPs' perceptions of emotional issues were contained within four context-related categories. These categories were directly attributed to the GPs in terms of family

interaction, awareness of mortality, young terminal patients, and emotional awareness. The participants perceived emotional issues as a major source of stress in the palliative care setting. They believed that there was the potential for depression if they became too involved. Acknowledgement of this was provided by the participants:

Palliative care can be an emotionally draining area. There are some difficult areas in medicine and I think palliative care is one of those. Yes, we do get depressed or stressed or emotionally involved with palliative care patients and their families. You can't avoid that.

I think if you really believe in palliative care then yes, it will evoke an emotive response. Obviously it will be a bit different because some patients will be known longer and have more of an emotional attachment but it's very difficult to look after a dying patient and not feel some emotional attachment to them.

Yes, I think in general practice you always have a relationship with the patient over a long period of time. A lot of other people involved will only have been involved with the patient during that illness whereas almost always you have known the patient since well before that illness and yes, you become very emotionally involved and yes, it can be quite stressful but also quite uplifting sometimes.

In the field of palliative care, emotional issues have been identified as a major source of stress for GPs (Field & James, 1993). The emotional labour inherent in the provision of palliative care is such that GPs may be unable to cope well with the provision of this care (Mulder & Gregory, 2000).

Family Interaction

Interacting with the family was identified by the participants as being one of the most important contributing factors to successful palliative care for terminally ill patients as was stated by one GP:

making him conscious of the fact that he was dying because they are all sitting around looking at him. I know that he was very uncomfortable.

Studies conducted in Australia and England have found that regional and rural GPs report having more problems dealing with the emotional distress of families than GPs in urban areas (Herd, 1990; Wakefield et al., 1993).

Awareness of Mortality

Working with palliative care patients was found to be an emotional issue for the participants because they were directly confronted with the reality of death which led them to contemplate their own mortality:

I have found that working in palliative care mode gives me a better understanding of my own mortality. Also my ability to deal with my own mortality ... because we are all going to die ... and I feel that I'm far more prepared for that myself than I was before I started palliative care.

It was suggested in the literature that closely identifying with terminally ill patients or their family members had the potential to raise the possibility of one's own death in a directly personal way (Field & James, 1993).

As the relatives of terminally ill patients have not been around dying people, it was also apparent that family members were not as accepting or as aware of death as mentioned by one GP:

Sometimes there is conflict between members of the family as to how the particular member should be looked after and I guess that creates difficulties. Because I personally believe in an afterlife ... I have no difficulty in seeing patients die but many family members don't accept that.

The only barrier is occasionally families don't accept it because they think it's the final showdown time.

A major source of difficulty surrounding the disclosure and prognosis of a person's terminal illness by GPs was found to be the relatives of the terminally ill person as they often believed that information should be withheld from the patient, thus causing great confusion and clashes about what information should be given to whom (Randall & Downie, 1999).

Young Terminal Patients

The participants indicated that they experienced emotional difficulties when faced with a young terminal patient, no matter how much experience or expertise they had:

Sometimes you get a tinge of sadness at someone where there is some sort of tragic circumstance like in a young person with cancer. I had a girl that I brought into the world who died of cancer of the breast at the age of 34. I found that very trying because I had looked after her since she was born, delivered three kids to her, and she was seated in the chair saying she had a lump in her breast that she had had for four months. She said she hadn't worried about it because she was too young to have a cancer. I found sitting in palliative care with her very emotionally strained.

The literature suggested that young terminal patients and their relatives generate closer and more emotionally laden contact with the staff that care for them. This is because staff may closely identify with a younger generation which raises the possibility of one's own, or one's children's, death and bereavement in a directly personal way that elderly patients do not (Field & James, 1993).

Emotional Awareness

The ability to emotionally detach from a highly emotional situation was perceived as necessary to avoid getting over-involved with the patient and family members. Age and experience appeared to be factors that influenced GPs awareness of emotional difficulties:

I think I've been in medicine long enough that I can disconnect myself. We do see some really sad things and no-one ever wants to have a terminal patient in their

Factors that seemed to influence GPs emotional awareness were age and experience. It appeared that GPs should be aware that emotional considerations at the end of a patient's life are as important as the physical problems for both the patient and family members.

Multidisciplinary Collaboration

Regional GPs' perceptions of multidisciplinary collaboration were contained within three context-related categories. These categories were directly attributed to the GPs in terms of a good supportive team, administrative changes, and changes to nursing staff. The multidisciplinary palliative care team is a central tenet to the philosophy of palliative care as the skills and knowledge of a variety of health care professionals is essential if the aims of palliative care are to be met (Randall & Downie, 1999). Teamwork in palliative care aims to successfully maximise the terminal patient's quality of life until death (Hull, Ellis & Sargent, 1989; Richards & Ramirez, 1997).

Good Supportive Team

There was unanimous agreement among the participants that a team environment in the palliative care situation was highly beneficial as the mutual support from other team members helped them to cope with the emotional, time, and management-oriented demands associated with caring for terminally ill patients:

Excellent. I don't think I'd like to do it by myself for a start. We don't have the time and perhaps not even the nursing and personal skills required so I think it works by far the best the way it is working at the moment.

I think it's not something that is done by a GP alone. It is a team service ... people who say they are going to be available 100% of the time are really making a big load on themselves. I think the community palliative care team is fantastic ... really top quality nurses who are experienced and very knowledgeable and very good at the communication skills.

Throughout the literature, teamwork was found to be essential in palliative care and that in any given case the GP, nurse, therapist, or volunteer each has a very important role (Allbrook, 1990).

It was found that participants viewed their role as that of co-ordinating care such as giving approval for treatment changes recommended to them by nurses and other team members:

You know somebody sort of has to take the lead and sometimes that happens to be the nursing staff. Perhaps they are the best ones to do it. So I don't have a problem with that. In fact, I find they're quite helpful. They often know more than we do.

It could be a combination of nursing care and medical care ... doctors and nurses working together with nurses doing most of the work at this stage and us kind of acting like a conductor in an orchestra.

GPs have been found to be the leaders and principal decision-makers of the palliative care team, however flexibility in adjusting to the role demands of the situation may mean, for example, that nurses may become more important than doctors for dying patients once the decision to palliate rather than cure has been taken (Hull et al., 1989).

Administrative Changes

Recently, the private and public hospitals in Bunbury have amalgamated into one major health campus. Nearly all the participants mentioned the fact that due to administrative changes associated with the amalgamation, the previous palliative care arrangement was replaced by a new system designed to increase efficiency and cost-effectiveness:

I guess the old guard has gone, and in a way a lot of people were disappointed because they thought that group of people who grew up with establishing the palliative care unit here weren't perhaps recognised as well as they should have been. I think it's always inevitable with change ... you're always going to upset

some people and I think they're still trying to find their feet here ... I find the current team I personally don't have any problems with ... they're very good and very dedicated and they do the job very well.

In general, the GPs were of the opinion that it was unnecessary to change a system that was working well; however the new system was perfectly fine. There were a few negative comments:

I worked very well with the palliative care team that we had in this area several years ago and over the previous years that was successfully destroyed in one fell swoop by administrative cross-tendering processes ... as far as I'm concerned, I think the earlier times were better.

In accordance with the literature, economic conditions, bureaucracy, and changes in government policy have placed pressure on rural and regional GPs (Porta, Busquet & Jariod, 1997; Strasser, Hays, Kamien & Carson, 2000).

Changes to Nursing Staff

It was found that the participants worked very closely with the nursing staff. After the administrative changes took place, the participants noticed the changes to nursing staff impacted on their support system:

I think the recent changes in palliative care in Bunbury have made some parts of it a little bit more red-tapeish. I think we lost some people with significant experience when the changes came in Bunbury and that meant that we got more calls from the less experienced nurses when that happened.

When the previous palliative care service in Bunbury was working they would actually get to know the people fairly early on in the cancer treatment. Just made themselves known and then six months later if they hadn't heard back they would catch up with them again.

I think it's important. I can see the need for ongoing education and I would be quite happy to participate in that if it comes along ... I have previously participated in palliative care workshops over a period of time and continue doing so. I think is important that you do that and that you do it well and learn as much about it as you can.

Other participants believed the current methods used to treat palliative care patients did not need changing or updating:

Continuing medical education for us is removing our life. It is. It's a real problem. I mean we work pretty hard and we don't get much time off. As far as palliative care goes, I don't think that there are any sorts of earth shattering advances that we need to be kept up-to-date with every six months.

I think it is something learned more from experience as opposed to having a course on palliative care being useful ... in fact I'd rather go to the football than a palliative care meeting!

Throughout the literature, there is evidence of a lack of continuing education and training for GPs in palliative care (Boakes, Gardner, Yuen & Doyle, 2000; Brenneis & Bruera, 1998; Charlton & Smith, 2000; Gott, Ahmedzai, & Wood, 2001; Llamas, Llamas, Pickhaver & Piller, 2001; Shipman, Addington-Hall, Barclay, Briggs, Cox, Daniels & Millar, 2001). Often it is only GPs who have an interest in palliative care who make the effort to attend lectures and seminars to further their learning about communicating with terminal patients and increase their knowledge of symptom control (Dunlop & Hockley, 1998). It was suggested by Block (2002) that the improvement of further education for GPs in palliative care will depend on a successful definition and refinement of attitudes, specialised knowledge, and skills in palliative medicine.

Treatment Change Updates

Pain relief and symptom control was frequently cited as the most important area to be kept up-to-date on by the participants:

I think one of the issues would be pain management of course. Symptom relief ... I think GPs often require a bit more help in managing it ... sometimes we don't do it well enough.

Time can go by and drug treatments can change and you often find palliative care sisters suggesting treatments that have come in the last two, three, or six months that you haven't heard about ... we'd just like to be kept up-to-date with the drugs because they change so quickly and the treatments change so quickly.

Pain and symptom control consistently emerged in the literature as the most challenging area for GPs in the care of the dying (Brenneis & Bruera, 1998; Hall et al., 1998; Shvartzman & Singer, 1998) as the GP is required to have an understanding of pharmacological, surgical, and radiological techniques in order to make the patient more comfortable (Yuen, Barrington, Headford, McNulty & Smith, 1998). It has been suggested that a lack of the necessary clinical knowledge for pain relief and symptom control could be due to a deficit in medical and graduate school curricula (Shvartzman and Singer, 1998).

The participants mentioned they would like to acquire more, or improve upon, holistic skills:

I think that the communication skills involved and family organisation skills probably in my experience haven't really been addressed. Workshop type situations with that area in mind would be useful.

Psychosocial needs and bereavement counselling for terminally ill patients were also cited as areas of educational deficit for GPs in the literature (Boakes et al., 2000; Field, 1998; Hall et al., 1998; Shipman et al., 2001).

Telephone Helpline

Regional GPs perceived the telephone helpline as a vital point of contact, education and support:

I think we in the country are very disadvantaged but that's a fact of life. I think metropolitan GPs in terms of education don't realise how well off they are. There are some very good systems in place and palliative outreach is one of those. It is run by a group of three or four consultants off their own bat in Perth and to us in the country that's a real bonus.

... if we need any advice we can always refer to palliative care physicians in Perth ... if you are really stuck like over a weekend or at night ... any time you've got a symptom complex that you're not managing particularly well, you can ring them up and they will give you advice.

A telephone service has been found to be an invaluable source of assistance for rural GPs about topics such as pain and symptom control (Gloth & Schwartz, 2000; Schroder & Seely, 1998).

In summary, half of the participants believed CME was essential whilst the others believed the current methods used to treat palliative care patients did not need changing or updating. The attitudes of GPs toward education and training were mixed and this difference of opinion appeared to be related to factors such as age, confidence, and experience. Pain and symptom control was consistently cited as the most important area to be kept up-to-date on by the participants. They also mentioned they would like to acquire more, or improve upon, holistic skills. Regional GPs perceived the telephone helpline as a vital point of contact, education and support.

Funding Issues

There was agreement among the participants of the need for higher levels of funding. The GPs viewed cost restrictions as a hindrance towards the potential for a better service than is currently available:

At some stage funding is always an issue. That's probably the biggest barrier and that affects availability.

In many countries health care budgets are decreasing and in order to justify the allocation of resources to palliative care, cost-effectiveness needs to be evaluated (Bruera & Suarez-Almazor, 1998; Higginson, 1993; Richards & Ramirez, 1997). It was suggested that budget reductions may lead to forced choices having to be made between different services and treatments for palliative care patients (Bruera & Suarez-Almazor, 1998).

The participants found that the problems of bureaucracy often got in the way of the provision of quality care:

I think the funding issue where you have restrictions on the time someone can spend in the palliative care unit in hospital depending on their insurance status ... the issues with regard to providing prescriptions and things like that ... I mean because it's done on a private basis, we are sort of double entry. We write it up on a medical chart at the hospital and then have to write it again on a prescription to refund the chemist their money and all that sort of thing. So it all really comes back to funding and red tape issues associated with it. We argue ourselves black and blue with governments about that but they won't change it.

In particular, economic conditions, bureaucracy, and changes in government policy have placed pressure on rural and regional GPs (Strasser et al., 2000; Porta et al., 1997).

In summary, there was agreement among the participants of the need for higher levels of funding. The participants believed cost restrictions impeded the potential for a better service than was currently available. The participants found that the problems of bureaucracy often got in the way of the provision of quality care to terminally ill patients.

Overall, one regional GP's thoughts on the provision of palliative care within the Greater Bunbury Division of General Practice was:

I think it has probably got to be better funded, better expanded because there are people willing to provide it down here it's just a matter of having the funds to do it ... to make them feel like it's worthwhile doing it.

Therefore, a number of factors were involved in regional GPs' attitudes to palliative care. Barriers to provision of palliative care by regional GPs were the potential for increased specialisation of palliative care in the field of medicine, the poor coping strategies of families of terminally ill patients, funding issues, and government bureaucracy. Supports needed to provide palliative care were identified as the multidisciplinary palliative care team, continuing education in pain and symptom control and spiritual issues, and a telephone helpline. It was apparent that there was a need to explore the issues of continued expansion and development of regional palliative care services and the continuing education and training of all regional health care professionals in the essentials of palliative care.

Implications for Clinical Practice

The implications of the study are; firstly, that the GPs involved in the study will become more aware of their beliefs, emotions, and behaviour regarding palliative care and how these impact on their daily practice. Secondly, the information gained from the regional study could be compared with similar research in the metropolitan area, so education and training programs for GPs about palliative care could be individually designed for both areas. Thirdly, the research will add to the scientific body of knowledge on the attitudes of regional GPs to palliative care.

The relevance for regional and rural GPs practising palliative care includes an increased awareness that palliative care incorporates a more holistic approach rather than a purely medical approach. The importance of the provision of good quality palliative care requiring effective interaction between GPs, nursing staff, and specialists is also of relevance. A further point is an increased awareness of problems with access to funding and CME. If GPs are aware of these factors, they may be able to plan to circumvent or minimise any negative impact on their general practice. Finally, rural and regional GPs often have greater family interaction with patients' families and accordingly, there is a need to be aware of the unique emotional issues that these GPs face.

It was anticipated that a potential limitation of the study would be a bias in the sample as GPs willing to participate in the study were likely to have a more positive approach to palliative care. This was shown to be the case but was not considered to be detrimental to the study as positive responses will help assist with a sound education program for future palliative care.

Possible future research could include conducting a similar study in ten years on GPs' attitudes to palliative care in the Greater Bunbury Division of General Practice in order to identify any changes to the factors involved, supports needed, and barriers to, the provision of palliative care. As spiritual and cultural issues were raised, a more in-depth analysis of GPs' attitudes to topics such as these could be examined. Alternatively, whilst examining palliative care, future research could be directed towards other caregivers' attitudes to palliative care such as family members and clergy.

Conclusion

In conclusion, the study explored regional GPs' attitudes to palliative care through semi-structured interviewing using a qualitative methodology. Five themes were identified: namely, quality of life, emotional issues, multidisciplinary collaboration, education and training, and funding issues. Barriers to the provision of palliative care by regional GPs included the potential for increased specialisation of palliative care in the field of medicine, funding issues, government bureaucracy, and the poor coping strategies of families of terminally ill patients. The supports needed to provide palliative care were identified as the multidisciplinary palliative care team, continuing education in pain and symptom control and spiritual issues, and a telephone helpline. Overall, it was shown that regional GPs' attitudes to palliative care were positive and that the provision of palliative care was fundamental to the role of a regional general practitioner. Results suggested that there is a need for the continued expansion and development of regional palliative care services and the continuing education and training of all regional health care professionals in the essentials of palliative care.

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Appendix A

Interview Schedule

- 1 What do you understand by the term palliative care?
- 2 What is your attitude to palliative care?
- 3 Can you describe your beliefs about working with patients who are terminally ill?
- 4 Does palliative care evoke any emotional responses from you?
- 5 Do you practice palliative care? Can you describe how you feel about your ability to provide care to terminally ill patients?
- 6 What is your opinion of continuing education for general practitioners in palliative care? What areas would you personally like to have addressed?
- 7 In general, how do you feel about working with a palliative care team?
- 8 How do you feel about the support network available to you for the provision of palliative care?
- 9 Do you believe that there are any barriers to the provision of palliative care?
- 10 What are your thoughts on the provision of locally based palliative care services for regional areas?

Appendix B

Information Sheet

The study in which you are about to participate is designed to determine general practitioners' attitudes to palliative care and is being conducted by Richelle Lee-Steere, a student of the Bachelor of Arts (Psychology) with Honours degree at Edith Cowan University, as part of her honours research. This study conforms to guidelines produced by the Edith Cowan University Committee for the Conduct of Ethical Research and has been approved by the Ethics Committee of the Faculty of Community Services Education and Social Sciences.

The proposed study will be conducted through a semi-structured interview consisting of ten questions inclusive of GPs attitudes to working with terminally ill patients, emotional considerations, locally based services and support, and continuing education for GPs in the field of palliative care.

Please be assured that any information that you provide will be held in strict confidence by the student researcher. At no time will your name be reported along with your responses. All data will be reported in group form only. At the conclusion of this study, a report of the results will be available upon request.

Please understand that your participation in this study is totally voluntary and you are free to withdraw at any time during this study and to remove any data that you may have contributed.

If you are interested in participating in this study or have any questions concerning this project, please contact Richelle Lee-Steere (Student Researcher) on 9791 1637, or any of her supervisors: Dr Lynne Cohen (9400 5575) or Dr Moira O'Connor (9400 5593).

If you are willing to participate in this study, please complete the following consent form.

Appendix C

Consent Form

I (the participant) have read the information sheet provided and any questions I have asked have been answered to my satisfaction. I agree to participate in this activity, realising that I may withdraw at any time. I agree that research data gathered for the study may be published, provided I am not identifiable.

Participant

Date

Student Researcher

Date

Appendix D

Question-Ordered Matrix (Example Only)

Themes					
	Quality of Life	Emotional Issues	Multidisciplinary Collaboration	Education and Training	Funding Issues
Question 1	GP-A, G: quality of life. GP-B, C: relief of pain. GP-G: caring rather than curative. GP-I, J: overall care rather than just medical.	GP-J: emotional support and explanation for the family.	GP-B: a team effort with doctors and nurses working together. GP-E: supportive care in a nursing sense or other necessary care.		
Question 2	GP-G: central part of general practice and central part of good medical care. GP-J: not the easiest part of general practice.	GP-E: positively essential. Very necessary and worthwhile. GP-H: won't go away so embrace it. Challenging, yet rewarding. GP-I: as important as giving birth	GP-A: problems working with the patient and relatives. GP-F: prefer palliative care over late-stage chemotherapy.	GP-C: ongoing changes and progressions in treatments.	
Question 3	GP-I: continuity of care.	GP- C, E, J: difficult area of medicine. GP-B: able to detach. GP-H: understanding of own mortality. GP-A, F, G: issues with family members.			
Question 4	GP-G: continuity of care.	GP-A, B, C, J: issues with family members. GP-F: manage to stay detached. GP- C, I: young terminal patients.			
Question 5	GP- E, F, I: seek advice from specialists.		GP-F, I: get help from nursing staff.	GP-J: fall back on training. GP-B: use telephone service. GP-G: room for improvement.	