

## **ORAL ABSTRACT #1 and co-winner of the top oral presentation**

### **Palliative Care in Humanitarian Crises**

#### **Introduction**

Palliative care has been neglected in humanitarian crisis situations as the imperative to save lives causes the needs of individuals who cannot be cured to be forgotten (1,2). The primary aim of this study was to assess the medical care situation for individuals with life-limiting conditions in a refugee camp.

#### **Methods**

We interviewed individuals with life-threatening conditions about their medical needs and challenges in accessing medical care. We also assessed local health facilities regarding the palliative care services which were available.

#### **Results**

A total of 313 individuals (156 with life-threatening conditions, 157 caregivers) were interviewed. The most common illnesses which were reported were severe physical disabilities (63%), treatment-resistant tuberculosis (21%), cancer (10%), and HIV/AIDS (2%). Pain was a significant problem for both children and adults, with 73% of individuals surveyed reporting having pain. Only one health facility surveyed had strong opioids available, and no patients surveyed had received opioids. Fifty-eight percent of patients reported that the medical care that they had received in the past month did not adequately address their medical problems. None of the health facilities surveyed were providing any palliative care and were instead focused on acute medical issues. The majority of patients surveyed (56%) reported significant financial problems which prevent them from getting medical care, other common barriers to medical care included a lack of suitable treatment at local facilities (18%) and difficulties with transportation (13%).

#### **Discussion**

In humanitarian crises, ensuring that pain treatment is available is essential to alleviate the avoidable pain and suffering of those with life-limiting conditions. Humanitarian health care staff should be trained to routinely assess and treat pain and other symptoms. Humanitarian health need to develop comprehensive plans to support the medical needs of individuals with life-threatening conditions, including medicines, medical supplies and barriers to accessing medical care.

#### **References**

1. Palliat Med. 2017 Feb 1;31(2):99–101.
2. Lancet Lond Engl. 2017 Apr 15;389(10078):1498–9.

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## **ORAL ABSTRACT #2 and co-winner of the top oral presentation**

### **Competence as Palliative Medicine Teachers in Competency-Based Medical Education (CBME)**

#### **Introduction**

The goal of this project is the development, implementation and evaluation of a faculty development (FD) session focused on assessment and provision of feedback in a competency-based medical education (CBME) setting.

Implementation of CBME involves delineation of the competencies required of learners, but also brings the competencies of clinical teachers to the fore.<sup>1</sup> Clinical teachers, who often assume their roles without formal training in education, are now called upon to champion CBME.<sup>2</sup> A dedicated faculty development strategy is required in the transition toward CBME.<sup>3</sup> Clinical teachers will be called upon to act not only as assessors based on repeated observations with timely formative feedback, but also as “coaches” or guides along a learner’s trajectory.<sup>4,5</sup> Evidence suggests that clinical teachers feel unprepared and/or lack the appropriate training to aid them in this transition.<sup>2</sup>

#### **Methods**

The session will start with an interactive exercise consisting of a video of a mock patient encounter followed by small group discussions centred on how one would assess that resident’s performance. This calibration exercise will allow faculty and learners to reflect on their assessment strategies in relation to their peers. Faculty will then participate in a mock clinical scenario and will provide feedback to one another using the tools that they gained in a previous faculty development session. This session might provide an ideal venue to have faculty and learners also provide input into the development of entrustable professional activities (EPAs) of teachers in a CBME system, which could then be utilized within the division (as per Dewey et al).

#### **Results/Impact**

We will ask participants in the session to complete a pre- and post-survey about their knowledge, skills and attitudes in regard to assessment and feedback.

#### **Discussion/Application**

A deliberate faculty development strategy is critical to the successful implementation of CBME.<sup>3</sup>

#### **References**

1. Walsh A et al. Preparing teachers for competency-based medical education: Fundamental Teaching Activities. *Med Teach* 2017; epub ahead of print.
2. Holmboe ES et al. Faculty development in assessment: the missing link in competency-based medical education. *Acad Med* 2011; 86: 460-467.
3. Dath D and W lobst. The importance of faculty development in the transition to competency-based medical education. *Med Teach* 2010; 32(8): 683-686.
4. Gercama A et al. Bridging the gap between CBME theory and practice: the role of a teacher community. *Perspect Med Educ* 2014; 3: 486-491.

5. Fraser AB et al. Preparing anesthesiology faculty for competency-based medical education. *Can J Anesth/J Can Anesth* 2016; 63:1364–1373.
6. Dewey CM et al. Entrustable Professional Activities (EPAs) for teachers in medical education: has the time come? *Med Teach* 2017; 39: 894-896.

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## **ORAL ABSTRACT #3**

### **Experiences Implementing a Perinatal Palliative Care Program**

#### **Introduction**

Perinatal palliative care is a relatively new frontier in the provision of pediatric palliative care. It is a patient and family centered approach which supports families who are expecting the birth of a child with a potentially lethal or life limiting illness (1,2).

We describe the characteristics of babies and families referred for perinatal palliative care at our institution over a 10 year period, since the perinatal hospice service began, including descriptive analysis of the diagnoses, interventions and outcomes for families who received perinatal hospice services.

#### **Methods**

A retrospective review of the medical records of all perinatal palliative care referrals during a 10 year period.

#### **Results**

We identified 78 cases where perinatal palliative care was provided. Fifty-one percent of patients were referred antenatally and 49% post-natally. Referrals were most frequently from neonatologists (47%), obstetricians (32%), or specialists in genetics/metabolics (12%). The average time between the diagnosis of a life-limiting condition and palliative care team referral was 4.5 weeks (range: 0-21 weeks). In 25% of cases the baby was stillborn, while 75% of babies were born alive. Thirty babies (46%) received care in the neonatal intensive care unit after birth, and 20 (30%) had care at a pediatric hospice. Sixty-seven percent of antenatal referrals had a specialized birth plan which was used to direct care at the time of the baby's birth and included considerations about resuscitation. In 84% of antenatal referrals, the baby received only comfort-focused care after birth, while only 46% of the post-natal referrals had comfort care and 54% received some resuscitation, which may have included positive pressure ventilation and chest compressions.

#### **Discussion**

There is a significant need for perinatal palliative services. When a palliative care team is involved, families are more likely to create a birth plan and choose comfort-focused interventions instead of intensive care.

#### **References**

1. *BMC Pediatr.* 2012 Mar 12;12:25.
2. *J Perinat Neonatal Nurs.* 2006 Mar;20(1):113.

## **ORAL ABSTRACT #4**

### **Journey Home: Working towards Cultural Safety in Palliative Care Services for Four First Nation Communities**

#### **Introduction**

An innovative project is underway with the two goals of 1. improving palliative care capacity within 4 First Nation communities, and 2. improving cultural safety in the services provided by non-Indigenous health care partners.

#### **Methods**

The preamble of the project included 2.5 years of conversations/focus groups and meetings discussing First Nation experiences of palliative care and related services<sup>1</sup>. Dialogue was between an evolving group of non-Indigenous health service managers, nurses, family/palliative care physicians together with First Nations Elders and knowledge carriers, care-providers, community members, and local/provincial governance structures. These conversations laid the foundations for relationship and trust building, and deeper exploration of areas of tension. Project leaders identified several themes of focus, including barriers to palliative care services, capacity challenges within communities, stories of culturally unsafe care, and preferences for traditional practices and perspectives. In response to this complex set of needs, tensions, and deficits in care, a palliative care project evolved, developed by a core planning team, in conjunction with a larger advisory group. Funding was solicited from multiple partners/agencies, with recruitment of participants from non-Indigenous and Indigenous care structures.

#### **Results**

The first phases of the project (October/November 2017) were characterized by cultural competency building in non-Indigenous care providers, and co-learning/reciprocal learning components<sup>2</sup> including a specialized LEAP for serving First Nations (Learning Essential Approaches to Palliative Care), and six “Community Learning Circles” giving voice to Indigenous traditions and preferences for palliative care. Planned components in early 2018 include co-learning case based team building, and a celebratory feast to engage broader community<sup>3</sup>. Participants have represented all aspects of the health care system, and First Nation care structures and governance.

#### **Discussion**

Evaluation and dissemination of the project has engaged local and provincial partners to explore new frameworks for Indigenous evaluation and healthcare decolonization

#### **References**

1. Improving End-of-Life Care First Nations Communities Research Team (EOLFN). Developing Palliative Care Programs in First Nations Communities: A Workbook (Version 1) Journey Mapping Guide (e-Book). <http://eolfn.lakeheadu.ca/wp-content/uploads/2015/07/Palliative-Care-Workbook-Final-December-17.pdf>

2. CJNR 2012, Vol. 44 No 2, 20 –42
3. Palliative Medicine, Volume: 30 issue: 3, page(s): 200-211

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## **ORAL ABSTRACT #5**

### **A feasibility study of home-based palliative care telemedicine in rural Nova Scotia**

#### **Introduction**

This research project was a feasibility study that evaluated the use of an Apple iPad and FaceTime to improve timely access to palliative care physician consultation for home-based palliative care patients living in under serviced areas of Nova Scotia. The study also assessed the patients' perceptions of their experience with FaceTime as a means of communication with the palliative care physician.

#### **Methods**

Patients received home-based palliative care physician follow-up assessment on an as-needed basis utilizing the FaceTime application on an Apple iPad. The video-link was facilitated by a visiting palliative care nurse during a regular visit. Participants were asked to complete a questionnaire evaluating their experience within 24 hours.

#### **Results/Impact**

Results indicated that using FaceTime via cellular data networks is feasible in rural areas of Nova Scotia. All the patients in the study reported that both the audio and visual quality allowed them to communicate easily with the doctor, and no consultations between the physician and the patient were terminated due to network instability. The palliative care patients also found the FaceTime encounter highly acceptable. 86% of patients reported they were 'satisfied' or 'very satisfied' with the experience, 100% stated that their medical concerns were addressed and 100% were willing to use FaceTime again.

#### **Discussion/Application**

The results of this study add to the limited literature that explores the use of telehealth in palliative care and demonstrate the utility of low-cost, commonly-used technology to improve access to palliative care in rural and under serviced areas.

#### **References**

1. Canadian Hospice Palliative Care A. Fact sheet: Hospice Palliative Care in Canada. 2012.
2. Economist Intelligence U. The 2015 quality of death index: Ranking palliative care across the world. 2015.
3. Canadian Cancer S. Right to care: Palliative care for all Canadians. 2016.
4. Canada's Health Informatics A. 2015 Canadian telehealth report. 2015.
5. Armfield NR, Bradford M, Bradford NK. The clinical use of Skype—For which patients, with which problems and in which settings? A snapshot review of the literature. International journal of medical informatics. 2015;84(10):737-42.

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## **POSTER ABSTRACTS**

The abstract by Dr. Teneille Gofton was the winner of the poster competition.