

BCHPCA FORUM | 2014

FRIDAY AFTERNOON SESSION MAY 9, 2014 4:00-5:00

Planning Conversations to inform and educate people about personal advance care planning and to encourage them in documenting their plans.

ROUNDTABLE

Critical Illness |

Sudden Palliative Diagnosis

MODERATOR: JUDY LETT, BCHPCA Regional Director – Fraser [Incoming]; Hospice Palliative Care Clinical Nurse Specialist, End-of-Life Program, Fraser Health; Co-Investigator, iPanel

INVITED EXPERTS

- DR. JILL MCEWEN, President-Elect, Canadian Association of Emergency Physicians; Assistant Dean, Undergraduate Education, UBC Medicine; Emergency Physician, Vancouver General Hospital, Vancouver Coastal Health
- DR. LYNE FILIATRAULT, Emergency Physician, Vancouver General Hospital, Vancouver Coastal Health; Clinical Assistant Professor, Emergency Medicine, UBC Medicine
- DR. TREVOR JANZ, Family and Emergency Physician; Regional Medical Director, Residential Care Interior Health East, Nelson BC
- SHERRY STACKHOUSE, President, Emergency Nurses Association of BC; Emergency Clinician, Lion's Gate Hospital

QUESTIONS

BCHPCA invites you to share your perspectives on the following questions. BCHPCA welcomes your personal experience in this discussion.

- the current challenges emergency and critical care specialists have in opening conversations about death and dying, and planning for care with patients in critical care and/or with a sudden palliative diagnosis
- the current challenges emergency and critical care specialists have in opening conversations about death and dying, and planning for care with loved ones of patients in chronic care and/or with a sudden palliative diagnosis
- the potential for emergency and critical care specialty practice organizations to partner with hospice palliative care organizations to promote public conversations on death, dying and advance care planning
- the potential for emergency and critical care specialty practice organizations to partner with hospice palliative care organizations to advocate for hospice palliative care in British Columbia

JUDY LETT: My name is Judy Lett. I'm a clinical nurse specialist for hospice palliative care and I'm the facilitator/moderator for this table today. And basically this session is on Critical Illness and Sudden Palliative Diagnosis. And our expert panel includes Dr. Trevor Janz, Family and Emergency Physician and Regional Medical Director from the Interior in Nelson BC. Did you want to add anything to that? No? Okay. Dr. Jill McEwen, President-Elect, Canadian Association of Emergency Physicians and Assistant Dean, Undergraduate Education for UBC Medicine. Anything else that you want to add?

JILL MCEWEN: Emergency Physician at Vancouver General [Hospital]

JUDY LETT: And Vancouver General. Okay. And we also have Dr. Lyne Filiatrault, en Française, and she is an Emergency Physician, Vancouver General Hospital and Vancouver Coastal Health [Authority]; also a Clinical Assistant Professor in Emergency Medicine at UBC. Do you have anything else that you would like to ...

LYNE FILIATRAULT: I do patient quality and safety and that's where, for the Emergency Department, that's where my interest lies. That's why I'm here – from a quality of care point of view.

JUDY LETT: Alright. We have one additional panel member who apparently is stuck in traffic and so she will join us when she gets here. Her name is Sherry Stackhouse and she is the President of the Emergency Nurses Association of BC, and she's an Emergency Clinician at Lion's Gate Hospital.

So the first question that we want to consider here is – this is all about planning conversations and how open those conversations and how we help to inform people and educate them about personal advance care planning and to encourage them to document their plans. So there's four different questions that I'm going to bring to you to comment on individually. And I would like to encourage the other participants around the table, after the speaker has made a comment, to just chip in if you have any additional comments. And so that's kind of breaking the rules a little bit but I think that a little bit more informal.

So the first question that I want to put out to you is, from your perspective as emergency physicians, the current challenges in emergency/critical care specialists have in opening conversations about death and dying and planning for care with patients in critical care and/or with sudden palliative diagnosis. So what are your experiences with that and what kind of recommendations around would you make around that in terms of supporting advance care planning.

[Sherry Stackhouse arrives]

JUDY LETT: Welcome. I'm Judy Lett the moderator and ... So this is Sherry Stackhouse, I'm hoping?

SHERRY STACKHOUSE: I just came from Squamish [BC]. Yes, it is.

JUDY LETT: I have the right person. She's the President of the Emergency Nurses Association of BC and works as an Emergency Clinician in Lion's Gate Hospital.

SHERRY STACKHOUSE: That's correct.

JUDY LETT: Just getting started. We have a small group so we've invited our guests to join us around the table. And we're just starting the conversation around current challenges in emergency medicine in terms of initiating those conversations and what your experiences have been. And so maybe I'll start with Lyne, you ...

LYNE FILIATRAULT: I think somebody, I guess Leslie [Rodgers, Fraser North Division of Family Practice] and I were in the same session in the morning and somebody really hit it on the nail and said that these conversations should not occur in the emergency. To meet it's a failure if you come to the emergency and the conversation hasn't happened. Somebody's dropped the ball and I'm not saying the family physician, I'm saying it could be the family itself with the ostrich effect, put your head in the sand. So we need to look at this as a failure, just as I look at an asthmatic coming into the emergency for care as a failure. It's a failure of chronic disease management. If your asthma is managed well, if you're educated about your asthma, you've got an action plan, you don't come to the emergency. So if you come to the emergency with an acute sudden illness and you haven't had the conversation, we've dropped the ball as a society. We talked about public health this morning, and I think we need to look at it that way.

And part of the issue, and I brought it up again this morning, is we're trained as doctors that if you lose a patient, it's a failure. And we need to reverse this and talk about the natural death, allowing natural death. And we're not there, both as physicians

but also as the public, of seeing death as a normal occurrence. My Mom says “Every day you’re getting closer to your death.” It’s pretty morbid but it’s true. And I think we need to as a society, re-look at the whole thing. But the difficulty ... you talked about when things are getting off the rails. And those are the family that are not prepared, that haven’t talked about what was important for their loved one. And I talked in the other session about the “seagull” effect which is the relative that flies in, often from California, and shits over the entire plan. [laughter]

COMMENTOR 1: Such an apt description.

LYNE FILIATRAULT: So that’s my two cents. And that’s why I feel as an emerg doc, and traumatized by the lack of conversation that people have, and I include specialists. I include my fellow oncologists particularly, if I’m going to point fingers, for not being honest about prognosis and not, and being paternalistic and not wanting to let the patient know for fear if they’ll lose hope or whatever. I think we need to be honest. I think we’re all grown up and we’re all going to die. And when you don’t have these conversations, then you put me, Jill, Trevor and Sherry in a very difficult position. We’re the people that are just meeting you guys and all of a sudden we’re saying “What do you mean you didn’t know? He [the patient] is getting palliative chemo, he’s got metastases here and there and this hasn’t happened?” I feel it’s unfair for me. It’s very traumatic. And it’s unfair for the family.

COMMENTOR 2: Has it happened to you in your life?

LYNE FILIATRAULT: Oh, a lot.

COMMENTOR 1: So how did you handle that? How did you manage that?

LYNE FILIATRAULT: Well often you have to backpedal. I’ve done a few things where, first of all I make sure that I’ve reviewed the documentation from the BC Cancer Agency to make sure that the conversation hasn’t happened and it’s just they’re in denial and I can refer back, “Well you met with so and so and you were talking about this and ...” So I try to revisit where they’re at. But I’m often saying, “This ...” whatever it is that just happened, “This is un-survivable.” Whether it’s a bleed. We often see inter-cranial bleeds or people deterring because of their cancer and I say, “This is not going to be survivable.” We’ll do everything to make people comfortable. And I try to move it [the conversation] to palliative care but it makes it awkward for me and often families find it difficult as well.

TREVOR JANZ: May again I make an apology for family doctors.

LYNE FILIATRAULT: Oh, I’m not blaming family doctors.

TREVOR JANZ: And bring another perspective that sometimes we can have forty-six conversations with the family and they come to emerg and are asking us, “We’ve never talked about that.” In fact we’ve approached it in a number of ways and they still, because of their own emotional unfinished business are not ready to face that. So there are times with patients when I with my colleagues have said “How could you have not done that?” and the answer is “What do you mean we haven’t done that? I’ve been talking to this guy about this for three years.” And we get to emerg and we still hear ...

JILL MCEWEN: You know I think in emergency there’s two completely different situations with the end of life and one of them is what Lyne is talking about is the patient, the palliative care patient. But the other one is the sudden catastrophic event.

JUDY LETT: And we're actually talking about critical illness and the sudden palliative event.

JILL MCEWEN: Yeah, so yes, there's a lot of, a whole set of problems with the patients that have palliative care. Do they have an advance care directive? Where is it? Often they'll come in without it. Or people don't know if they have one and we're faced with the patient and we have limited information. So you're almost forced to carry on now with what you have but try and gather information as you go. And family members may have different opinions and family members override their ... They panic at the last minute and they ...

COMMENTOR 3 []: "I'm not ready."

JILL MCEWEN: Well, yeah, or if the patient bleeds or vomits blood, they bail and they bring the patient in there. So they need to be taught it's okay to not do that. And nursing homes bail, so we'll get the level of care – we'll get level 2 and level 1 patients that are still brought in, and that's ... But in terms of the acute event, yes it would be really nice if every human being had an advance care directive from when they're 10 [years of age]. So that when they have a subarachnoid hemorrhage when they're 17 [years of age] or they drive along in a motorcycle on a beautiful day like this and hit a car, but they don't [have an advance care plan], then we have to have those difficult conversations with their loved ones. And yet the problems are, we don't have any relationship with that family. But that's okay. We learn how to deliver bad news. We have to find a quiet place in an overcrowded department where patients are down the hall away and there is no [un]crowded place. We have time pressure of the next patient coming down the line that we have to go and treat.

So one of the things that I would advise is to learn how to deliver bad news. And we do teach that in the medical school curriculum and in residencies, and to do the interdisciplinary team approach. We rely on our social workers and they come in with us while we deliver. And we all sit with the family for a bit. But then we kind of have to extricate ourselves. And then we have the spiritual care person from the hospital that comes to be with the person. So we really have to rely on that team and then go back. Advice would be to take the responsibility off the loved ones.

So I guess another problem is, it's not always clear cut if something is not survivable or not and we always have to err on the side of the benefit of the doubt unless we know for sure. And so even if I have a large inter-cranial bleed that on CT scan I don't feel is survivable, I'll always ask a neurosurgeon to come for a second opinion. And then I think it makes the family feel better too. They don't know me. And I'll show them sometimes the CT scan and get the neurosurgeon so that you're saying, "This ... the right thing to do is to not continue with care." So I've heard people say, "What do you, do you want us to extubate?" or something like that. And I think that's really unfair to the family who wants to do everything.

Other problems are the cultural barriers that I know it looks like you've already talked about. Because it's a very strong Asian culture to not, to do everything. So/and to keep someone alive. And waiting for relatives to come. And you just kind of have to have a way of saying nicely, "That's not really the right thing to do" for anybody involved, so ...

SHERRY STACKHOUSE: I think having your team ... at Lion's Gate we have a palliative care on-call physician. So I look back over my thirty years and we're much further ahead now. So when you have that difficult sudden illness, we can call the palliative [care team] – we call them the "peacocks" [laughter] – and they can be in the department within ten minutes sometimes. And I've seen them come in and they've had to have that, over the patient, very difficult conversation. But the emergency physician and the team have identified "This is a palliative patient" and immediately we bring our team in and then they take over that very difficult conversation. And it's distressing, but it has the better outcome than ...

JUDY LETT: So they have more of the time and they have developed skill ...

SHERRY STACKHOUSE: And then know, they generally know the group of patients. The other really difficult situation is our systems don't talk to one another. The electronic records, so if you need timely information in that critical moment, it can be really difficult.

TREVOR JANZ: So timely information is an information technology piece that needs to be part of this.

SHERRY STACKHOUSE: But we have come miles from when we started where every palliative patient would come in and we would have no referral process. And so they're identified earlier. We have the palliative care on-call physician who can come in and ... Because like you were saying, you don't often know the outcome. We get a lot of sepsis in our palliative patients and some of these patients turn around and they have quality of life after. They can look really sick in the moment and ...

LYNE FILIATRAULT: A lot of that work was done by [Dr.] Peter Edmonds in his job ... amazing job ... way ahead of where VGH [Vancouver General Hospital] is.

SHERRY STACKHOUSE: Dr. Peter Edmonds has done amazing work ... They even have a community bed so they often can get the patient right to the community bed and they don't languish in our ED [Emergency Department] anymore. They used to spend several days.

TREVOR JANZ: Which is not a great place for a palliative patient.

COMMENTOR 4 [Joyce Kuhn, Comox Valley Hospice Society]: No. It's just one of the worst in my opinion.

SHERRY STACKHOUSE: Absolutely. So if you can bypass that, the only thing we haven't got past is if you end up in the emerg, and the community bed is open, we can't use it. So we're working to get past that last ...

TREVOR JANZ: Catch 22. You need it so you can't have it.

SHERRY STACKHOUSE: Yeah.

LYNE FILIATRAULT: It's also supported the residential care so that dying at home – what is home nowadays in the residential care versus we see residential care where there's no support for this and a patient's level of intervention is changed and at the end when family are uncomfortable or a lot of care aides now run long-term care, so they get transferred into the emergency because there's no support unfortunately.

COMMENTOR 5 [Jeanne Fahlman, Nanaimo Community Hospice Society]: That's the problem I think right now is that if you, a lot of families that I know – I came through [it] with my family and I'm just heading back into it again with my Mother but we're lucky. We have a support team at home – my sister. So we know. We have a plan. We're going to keep her home. We're going to look after her just like we did with my Dad. In some cases people go into the residential homes. But we know in Nanaimo that in one of our big homes, there's three people on at night. And we know there's palliative people. And there's over 150 patients, residents. That's unacceptable. So it's just as bad as emergency in some cases because they're going to be, at least in emergency, there's people there. But some of these people are left to sleep with maybe one or two aides on

and one RN [Registered Nurses] on call. And so that's the part that's so disheartening, is there's so many people falling through the cracks.

SHERRY STACKHOUSE: There was a great program in parts of Calgary where hospitalists take call for whole facilities because the GPs [General Practitioners] are incredibly stressed. So they're covering for all their other colleagues. So if you get a call from residential and you're getting maybe not a good story and you don't know anything about this patient. But I'm very impressed with the Calgary system where a hospitalist covers one or two facilities and is preventing admission to ED [the Emergency Department] and providing better quality of care. That's what we need is care to go where the patient is if it's possible.

TREVOR JANZ: Upstream care. So I would love people with chronic diseases to have this conversation with their specialist physicians. For somebody with congestive failure, end stage COPD [Chronic Obstructive Pulmonary Disorder] or liver failure from the Hep C [Hepatitis C] to not have had these discussions and then arrive at emergency is a clear failure of the system. And we have chronic disease management programs and this has to be a part of the upstream care that says, once you're labelled as having a chronic disease – congestive failure, renal failure, COPD, end stage diabetes – that that has to be a conversation that happens and there has to be a robust communication system around that.

SHERRY STACKHOUSE: How many programs or hospitals do it like Dr. Edmonds where they're identifying from the chronic disease population. So we have a huge number of CHFers [Congestive Heart Failure] who are already identified and moved into the palliative program pre-emptively. And we didn't do this a few years ago. And that's making a huge difference. If you have "X" number of visits, then you are referred and the conversation happens. And we have set criteria.

LYNE FILIATRAULT: So free admissions for CHF; free admission for COPD. As soon as you're diagnosed with ALS?

SHERRY STACKHOUSE: Yeah.

LYNE FILIATRAULT: He's trying to bring that to Vancouver Coastal [Health Authority] – VGH [Vancouver General Hospital] – and it's go to be, it's going to take a while.

TREVOR JANZ: There's significant systemic obstacles to that. It takes a while to put that together. But when we're doing that well, it really does help because oftentimes if they've had those conversations, them coming to emerg is not necessarily the default answer for every crisis. We start thinking a little more selectively about "These are the situations where we need emergency. These are the situations where in fact we can access other resources, and not do that."

JUDY LETT: And can I just ask people to identify who they are for our recording so that's part and parcel of ...

TREVOR JANZ: I have another point but keep this is as a comment on that. No issues if you're commenting on that idea.

COMMENTOR 4 [Joyce Kuhn, Comox Valley Hospice Society]: You're talking about having the conversation with your doctor or the specialists, whatever. I'm Joyce Kuhn and I'm a volunteer with Comox Valley Hospice [Society]. And I'm a retired critical care nurse.

TREVOR JANZ: You know this territory very well.

COMMENTOR 4 [Joyce Kuhn]: Yes I do. And I'm very motivated. I'm providing workshops on advance care planning for people in the community. One of a team actually in the Valley. And I think quite a few hospices have advance care planning groups that are providing workshops and what not. And so what we see happening is the doctor will identify that the patient certainly does need to – well everybody does need to do advance care planning. So how do we get the word out to everybody.

TREVOR JANZ: But especially these ones because they're going to need it this year.

COMMENTOR 4 [Joyce Kuhn]: But especially they'll identify one. So given the time constraints and all the rest, and they're handing them the "My Voice" booklet and saying "Here, you need to do this." Well, here's this person facing this 53 page document and going "Oh, oh." It's very intimidating even for myself.

So we've taken it, what we're really providing is a two-part workshop. The first part is really about identifying beliefs and values and this sort of thing – what gives your life meaning, around having the conversation, and then the second part is going through this booklet and making some sense of that. So it's like, my main question is, been what we've been telling people is, once you've figured out, you've got it ready, you have to include your family doctor in this. When you're having the conversation with your loved ones, you must also have this conversation with your doctor. Well they say, "Well, my doctor never has time." Or "He doesn't want to hear it." So can if they, can if we advise them, "Make an appointment to see your doctor just for the purposes of advance care planning" is that acceptable? Can physicians bill for that?

TREVOR JANZ: That's an ideal. Yes. Absolutely.

COMMENTOR: So that is an appropriate use of a physician's time.

TREVOR JANZ: If I don't have a shopping list of six things to do and this is the one thing that we were to accomplish, I would love the time, a block of time that says, "Let's do this."

LYNE FILIATRAULT: I didn't think the GP [General Practitioner] had the billing code if the conversation was outside the last six months. So there's a billing code for the GP for the end of life but I didn't think you had it for the advanced care plan. The specialists do and when we talk to the Doctors of BC [BC Medical Association], they're not billing. We know that. They're not using that code. But the GP, my understanding is one of the barriers, and I should have asked [Dr.] Cathy Clelland [an expert in the Family Physicians Roundtable] what they were and where they were with this. Yes, they have the end of life part – the last six months they can support and bill for that, to see ...

TREVOR JANZ: But outside of six months you can't do that?

LYNE FILIATRAULT: But if you've got someone who is healthy or not in the last six months, they may not be ... at least that was my understanding.

JUDY LETT: So how does that work for a patient who has a chronic disease and they've had, say CHF, COPD for years and they have a constant catastrophe and recovery, catastrophe and recovery and that's sort of their pattern. So they could die at any one of those points, so ...

TREVOR JANZ: So we should have had the conversation last year if they're at that stage thank you very much.

JUDY LETT: Yeah. Exactly. So why can't there, and I did read a couple of articles a few years ago about something that's happening in the United States called a simultaneous model where palliative care and curative care are paralleled. And that you apply the principles of palliative care all the time at the same time. And a lot of that is focused around discussions, advance care planning and also disease management. So impeccable disease management but paired with all those other things as well.

COMMENTOR 4 [Joyce Kuhn]: But how are people going to have the conversations with their doctors if their doctors can't even bill for it? Perfectly healthy people need to be able to do that.

JUDY LETT: I could be wrong. As far as I know, they can bill for that.

LYNE FILIATRAULT: They can? So maybe I'm wrong. Maybe it's changed.

COMMENTOR 4 [Joyce Kuhn]: This is something I really need to find out isn't it?

JUDY LETT: I know that it's in the works but it's not there right now.

COMMENTOR 5: But you know, one of the things ... My name's Jeanne Fahlman. I'm with the Nanaimo Community Hospice [Society] and we belong to the Federation of Hospices on Vancouver Island we formed for advocacy and for a larger voice. And it's really worked because what we're doing and what Island Health [Authority] asked us to do is take on as one group of people ... We're the natural – our volunteers are the natural people. We're in the palliative care unit, we're in the community, we're in their homes. We have trained our volunteers. It's a natural conversation for us to have. I don't know, and I don't want to speak out of turn, but I don't know that it's the doctor's job to do that when there are so many other people that are, that can do that as well. Not that you shouldn't do it but ...

TREVOR JANZ: It's all of our jobs.

COMMENTOR 5 [Jeanne Fahlman]: It's all of our jobs. That's right.

TREVOR JANZ: If all of us are doing this and they're getting it from the nurses and the community health nurse and the family doctor and the emerg doc and the guy on the radio. We're hearing about this ...

COMMENTOR 5 [Jeanne Fahlman]: Everybody so that they promote it.

LYNE FILIATRAULT: But the IHI took it out of the doctors' ... their model when the Institute of [for] Healthcare Improvement in the [United] States. It was Ellen Goodman that started this after she went through it with her mother dying of Alzheimer's. And she called it the "Kitchen Conversation" [The Conversation Project]. And I think that's a good model. And in the States, they really promote it around Thanksgiving. I'm repeating myself – I'm sorry Leslie. But Thanksgiving is when the Americans – it's a day, a big deal. It's the one holiday where the whole family gets together and they talk about it around the turkey basically. And that's where she started it, on the Kitchen Conversation ...

TREVOR JANZ: Everybody sits down for dinner. Let's talk turkey.

LYNE FILIATRAULT: And the second part now is “Are you conversation ready?” And that’s when she’s bringing it back to the healthcare: “Are you guys conversation ready because these people are going to come to you with this. Where do we store it? How do we transfer it?”

COMMENTOR 4 [Joyce Kuhn, Comox Valley Hospice Society]: That’s why we’re saying have the conversation with your doctor because at least when the person presents in the emergency department, then there’s an effort to get a hold of the GP.

COMMENTOR 5 [Jeanne Fahlman, Nanaimo Community Hospice Society]: Wouldn’t it be wonderful if we could have it on a chip? On a card on our health card eventually. Wouldn’t that be something to aim for, so when you go in you have to show your health care wherever you go at whatever health institute. If you had that document chipped in somehow ...

TREVOR JANZ: I like it in the computer database so that your family doctor has that conversation and anybody who accesses it anywhere anytime has access to that.

COMMENTOR: That’s our goal.

TREVOR JANZ: But that’s the Holy Grail and it’s still a long ways away.

JUDY LETT: Sherry has a comment.

SHERRY STACKHOUSE: I just wanted to ask the group whether ethics plays a part in everyone’s organization because we’ve had a couple of instances recently where you talked about the “seagull”. We had a very tragic situation of a GP with end stage ALS coming in and multiple family members wanting to provide advanced care when the spouse was expressing his wishes. And he had an advance directive but they couldn’t find it. So the emergency physician was very torn because they had to put a breathing tube in. And/so it had a happy ending in the end but we ended up taking our case to Ethics because who supports the emergency physician and team when you do things that are against what the patient wants? And so we were discussing one of our recommendations from the Ethics was: “Who supports within your organizations?” So this occurred at 3:00 in the morning of course when no one with the knowledge is at work. And so are you familiar with being able to consult people in these difficult times when you’re having to sort out these kinds of situations?

LYNE FILIATRAULT: Risk Management Team. Darren Kopinsky ...

SHERRY STACKHOUSE: Well Darren said he would answer but of course not at 3:00 in the morning.

JILL MCEWEN: Well no, but we would consult one of our colleagues so ...

SHERRY STACKHOUSE: Which we did ...

JILL MCEWEN: Yeah. And ALS, intubation? It’s just like ...that must have been a junior physician.

SHERRY STACKHOUSE: No it actually wasn’t and the difficulty was there were two family members saying “You will put this tube in. Dad didn’t understand what that meant.” And then the wife said “I will let the children say because I can’t live with them being angry with me.” [Audience: Oh!] So we had these very intense conversations. So we took it to our Ethics. And what ended up happening was he woke up. He said “Take this tube out. I love you all. Let me go.” In the end the family felt that

they got an additional goodbye. And I just wondered what other people were using, who the support was because Darren was not available when they needed him.

LYNE FILIATRAULT: Yeah. Okay. But by the law, the substitute decision maker is the spouse. It's best of all if you can find the advance directive, which is typical of ALS ...

SHERRY STACKHOUSE: Which we couldn't, at 3:00 in the morning.

LYNE FILIATRAULT: And ALS, sometimes the person who is faced with ALS will write it as an advance directive because the spouse may not be able to let them go. So that's one of the cases where it's worth having a written advance directive because you know at some point your brain's going to stop. But by the rule, you're just making it harder when she's deferring to the kids. But by the rule if she says "He told me this is what he said: he didn't want to be intubated." And she's the first one on the list of substitute decision makers.

SHERRY STACKHOUSE: So they went through all of that and it was a very rich discussion with the Ethics team. And the physician was very clear what the right thing to do from a legal perspective [was]. They were trying to do the right thing for everybody, for the family.

JILL MCEWEN: It's very rare that you get a case like that. Maybe once every ... I might have had three or four in my whole career. And so I think in those one offs, I think it's okay to just take some time and if you have to, if the physician's not comfortable with it and you can see the family is going to be blaming themselves and there's some kind of conflict, I think it's okay to just take some more time, like what happened here.

LYNE FILIATRAULT: I would go see Jill and say "Can you do a consult?" [laughter]

SHERRY STACKHOUSE: And get a second opinion and I need it in writing.

JILL MCEWEN: And another person coming and talking to the family and saying "I realize that you want to do everything. But this is just not the right thing to do."

SHERRY STACKHOUSE: So if it had been 9:00 in the morning, or 3:00 in the afternoon, there would have been lots of people to consult with. He was the only physician on.

JILL MCEWEN: Well then there's always a VP Medicine you can call. You can get other, for the situation it's not so much palliative. But I've had patients who want their loved one admitted and they don't need to be admitted. And they're just saying, "Well I'm not taking him home." So in a case like that, you can get the VP Medicine to come and talk to them. In the end, every single time they've ended up getting admitted because nobody wants to take that on.

MULTIPLE COMMENTORS: The conflict. Take on a family member.

COMMENTOR: Did they not have a care plan for this ... ?

SHERRY STACKHOUSE: They called 911. So he had pneumonia. And he got really quickly sick over six hours, so they called 911.

JILL MCEWEN: And there was no MOST [Medical Order to Stop Treatment] because you don't do MOST.

MULTIPLE COMMENTORS: That's just Fraser Health [Authority].

LYNE FILIATRAULT: But regardless, my experience with people that have families that know, they've been, they've sat through the conversation that is "Do Not Resuscitate", something happens at home, they call 911.

MULTIPLE COMMENTORS: They do. They panic.

LYNE FILIATRAULT: You cannot give them the responsibility of calling or not calling. So what you need is you need the green sleeve or something on the fridge for the paramedics to say "Okay let's load him up but this is what we're doing."

JILL MCEWEN: Did the paramedics bring him in?

SHERRY STACKHOUSE: Yes.

JILL MCEWEN: And where was the green sleeve?

SHERRY STACKHOUSE: They couldn't find it.

JILL MCEWEN: It wasn't on the fridge?

SHERRY STACKHOUSE: No, the wife couldn't find it.

JILL MCEWEN: Because that's the first thing that a paramedic looks for. That's where they look.

JUDY LETT: And you know, that's the thing that scare me about advance care directives actually. Once you have a written document, they get lost. Who's got the right copy? In some ways I think it's more about the conversation than it is about the piece of paper.

TREVOR JANZ: It is. It's about the conversation.

JUDY LETT: Because how could you account for every single situation that could come about? You just can't.

LYNE FILIATRAULT: And if you look at the Bentley case, [Margot Bentley] who didn't want to be force fed and it's written there [in the advance directive], while they're not considering spoon feeding if you've got a reflex where you're going to, where you can open your mouth, that's not force feeding because she's opening her mouth. So she would have been better not to have it as an advance directive because the family would have said, "These were her wishes". And this would fall there. But now that it's in writing ...

[BCHPCA NOTE: Margot Bentley wrote and signed a "living will" before the Legislature of British Columbia amendments to the Health Care (Consent) and Care Facility (Admission) Act, [RSBC 1996] Chapter 181 came into effect on September 1, 2011. The living will was not recognized under this amended legislation.]

COMMENTORS: I just can't get over ... everything is crazy. That's a very difficult case.

JILL MCEWEN: I think some of the public is worried about having an advance directive with too much detail because they're worried, given the inverted [population] pyramid, the Baby Boomers, that the sparse health care dollar, that they might be written off prematurely. And I've heard that before. So it's not ... there's the other side of the coin because I know not everybody wants to put everything down. There's somethings everybody can agree on: nobody wants to suffer, nobody wants to be a burden on their family, no one wants pain – that type of thing. But it's not always so clear cut. So it gets into the grey zone and we want to be really careful that we don't have the thin edge of the wedge or something that can be open to interpretation and being misused in cases when, oh the hospital, not that anybody would do it consciously, but there's this pressure of the system. And that people might be not resuscitated that otherwise would.

JUDY LETT: And people might want antibiotics at a certain point in their trajectory. But maybe later on they don't, so ...

LYNE FILIATRAULT: It changes. And you have to have the ability to change what you wrote.

COMMENTOR 5 [Jeanne Fahlman, Nanaimo Community Hospice Society]: Well and that's part of why conversations – everybody has to be able to have those conversations. And building capacity around that. And your family physician and whoever the palliative physician might not be around at that time. So whomever is standing in front of them has to be able to talk to them.

SHERRY STACKHOUSE: I heard a thread earlier about the conversation. And as an emergency nurse, if someone needs to come into our department to die because they can't die at home, I also think we have to be prepared to do that. Because when my step-father passed away in Fraser Health [Region], and I went to visit my Mom and I thought "Oh Mom, you have no idea that he's going to die and he's going to die in the next couple of days." And so we had to get him admitted because my Mom just wasn't prepared to ... And for many patients and families, they want to care for them up until the end, but they don't want their loved one to die in the home. And we have to be okay with that.

JILL MCEWEN: Well it's a matter of educating people. We know 100% of people want to die at home and only 70% of people die at home.

SHERRY STACKHOUSE: Because it's frightening. And if you haven't seen it ...

JILL MCEWEN: So yeah, and so the loved ones need to be told that's what they want.

SHERRY STACKHOUSE: It's okay.

JUDY LETT: And so we can support them in the community as much as possible as long as possible. But often people want to stay at home for as long as possible. But for that very end, "I want to go to hospital."

TREVOR JANZ: Yep. It exceeds the family's capacity.

COMMENTOR 6 [Leslie Rodgers, Fraser Northwest Division of Family Practice]: But we try to help them make plans so that hospital doesn't become one of those options. It's either hospice, tertiary unit. It's "Do you want to die in hospital?" No, not really. It's not the best place to die.

LYNE FILIATRAULT: But there's no capacity it seems. It's the capacity that's the problem.

SHERRY STACKHOUSE: That's why our community bed is so helpful because they don't have to come through the emergency doors. There's a unit waiting upstairs for them that understands that whole process.

JILL MCEWEN: Except it's not, it's always full. It's not available.

SHERRY STACKHOUSE: For you guys [emergency department referrals] it's not. But we at least have this rule where you can't use it unless that patient is coming from the community and then they bring them in and they endeavour to either move them to hospice ... There's a real push to looking after your patient population in the right space and we're a little bit smaller so sometimes that's a bit easier.

COMMENTOR 4 [Joyce Kuhn, Comox Valley Hospice Society]: And some of the smaller units yet, like in Comox we have no hospice buildings or beds and often times the hospital is [at] capacity. Even though the plan was for the person, or they would like for the plan to be for the patient to not die at home, they don't have any other choice because they don't get to admit them to the hospital because there's no beds and there's no hospice.

JUDY LETT: There's no beds and sometimes the family don't have the capacity to manage at home. You have one caregiver at home. They're completely maxed out.

COMMENTOR: This is what's happening in areas like ours.

JILL MCEWEN: I think before we can mandate the people need to stay in either home or a nursing home, they have to have the right tools to handle the issues. We see all the time nursing homes that should have kept their patient at home, at the nursing home. But they don't really know how to manage things. And they're not getting managed properly. Like you were mentioning the only three people who, that are on overnight.

COMMENTOR: And they're care aids. There's only one RN.

JILL MCEWEN: So how can you, yeah. They aren't getting the right analgesics, they're no getting treatment for shortness of breath. I/we can't ... we have to fix that first. You're next.

TREVOR JANZ: I'm the Regional Medical Director for long term care. This is my job is to create capacity in the system and creating a system in the long-term care home where the nurses in long-term care are supported by a physician who is dedicated, who is on the end of the phone, who is available in real time and coming and seeing the patients on a regular basis, who has built a relationship with the family, who knows what's going on. I can't remember the last time a patient of mine ever went to the hospital to die.

LYNE FILIATRAULT: I think it's the same system on the North Shore that Peter Edmunds did. So we're hoping that it will come to our institution, to all our institutions.

TREVOR JANZ: When you've got the nurse and the doctor and the family working well together in residential care, we certainly don't need your world and don't want to use it because we can do way better.

LYNE FILIATRAULT: Well that's why I say, to me it's a failure. We need to look at it as a failure – something, why is this happening? And I don't blame the nursing homes for sending the patients in.

TREVOR JANZ: I think it's a disengagement of the family doctors with the nursing home. They're not talking to each other and you need them working hand in glove to do this in a good way.

JUDY LETT: So I would assume that those conversations are happening when people are admitted to long term care facilities. Is that correct?

TREVOR JANZ: In an ideal world, someday the Holy Grail. In my world as a house physician where I'm there every week and it's happening beautifully, that's great. There are lots of long-term care homes that can't get a physician to darken the door for weeks and months at a time, and then there's problems.

LYNE FILIATRAULT: That's what you hear on call, is that you can't get a hold [of the family physician], so they send the patients to emerg.

TREVOR JANZ: So there's an initiative through the BCMA coming, for new incentives for GPs to come into residential care and giving them incentives for that. "But I don't want to give you the money unless you sign up to a contract that says 'I will come and see my patients. I will admit orphan patients. I will be available on call. I will follow patients into the hospital as their MRP [Most Responsible Physician].'" So I'd love a list of deliverables that says "I as a GP am willing to sign up and step forward." And GPs are busy, busy, busy and they're going to have to push aside or get rid of something else in their life to make space for this. So we have to provide some incentives for them to do that. But absolutely, residential care is kind of broke at the moment, kind of broke. So we've got lots of work to do around that. And when that works better, I think this problem will much better.

LYNE FILIATRAULT: We did have funding a couple of years ago, we had funding two years ago on the "My Voice" booklet. So we did dinner conversations with GPs. It was myself, Wallace Robinson – a social worker from St. Paul's [Hospital] – and a retired palliative care nurse. And loud and clear, the GPs were saying "We can't take on more." So, which goes to having the conversation outside – spending the time and then bring it back.

TREVOR JANZ: I love the idea of having workshops which people can do as a group. The group learning situation where you are with fifteen other people. It makes it a whole bunch safer just to sit in a room with other people.

COMMENTOR 5 [Jeanne Fahlman, Nanaimo Community Hospice Society]: Yeah, and it's really popular. The first three that we put on, we filled thirty people each time and there was wait lists. So there is ...

TREVOR JANZ: An appetite.

COMMENTOR 5 [Jeanne Fahlman, Nanaimo Community Hospice Society]: There is an appetite for it and people really want to do it. So we just don't want to drop the ball. We want to make sure that we keep doing it and keep providing that, so...

TREVOR JANZ: And if it exists and it's stable, then GPs will learn that it's there and start using it as a tool. But it has to be available on a consistent basis because if they can't find the number and "Oh it worked last year and now the coordinator's gone. And oh, we haven't ... I phoned the number. There was nobody there and the program got shut down" blah, blah, blah. It has to be a stable service.

JUDY LETT: So it seems to me that this group medical appointment approach might be very, very effective for all the different chronic disease management groups and for the GPs and you can probably think of a lot of different scenarios in which that would work. Maybe even in a long-term care facility. Or maybe not ... looking at the ...

TREVOR JANZ: I talk to, actually I speak to resident family councils and that's actually a great way to access that is to get the engaged families together and have these conversations with them at that point.

JUDY LETT: Okay. I need to transform this conversation to a slightly different topic now or I'll be in trouble. [laughter] So we need to think about as emergency care providers and critical care specialty, how do you think your organization can partner with hospice palliative care organizations to promote public conversations on death, dying and advance care planning?

TREVOR JANZ: I think we just answered that.

JUDY LETT: You just answered that, okay. And I guess this is all really, we've been talking about this as well in terms of advocating for hospice palliative care and working together with the hospice palliative care organizations, so I think we're all on track with that.

LYNE FILIATRAULT: I have a question. So if you're doing – well for both of you actually – if you're doing this conversation, is it under the title "hospice"? Because we find patients that don't like hearing "hospice", they don't want to hear "palliative". So using a different title ...

TREVOR JANZ: It's almost as bad as the "d" word.

LYNE FILIATRAULT: Yeah. It's just on par with the "d" word.

COMMENTOR 4 [Joyce Kuhn, Comox Valley Hospice Society]: Advance care planning.

LYNE FILIATRAULT: So just call it advance care planning?

COMMENTOR 4 [Joyce Kuhn]: Yeah, and it makes a great link to hospice.

LYNE FILIATRAULT: And you do utilize the hospice font.

COMMENTOR 4 [Joyce Kuhn]: Right. Then we do talk about that we are part of hospice and under the umbrella of hospice. But when we advertise it, it's advance care planning and it all goes with that and really we have no mention of hospice except that the phone number to sign up for workshops is the Comox Valley Hospice Society number.

COMMENTOR 4 [Jeanne Fahlman, Nanaimo Community Hospice Society]: Yeah, and we introduce it as an Island Health initiative that “Consider the Conversation.”

TREVOR JANZ: Island Health. It’s about health – good health.

COMMENTOR 5 [Jeanne Fahlman]: Yeah. Well we just do that, that’s how we do it because we’re on the Island so it’s a ...

COMMENTOR 4 [Joyce Kuhn]: But we do also link it with, we do talk about that we are involved with hospice as well. And certainly some, without fail some questions will come up about, not necessarily advance care planning but also about other aspects of hospice. And it’s a ... I know Terry Odeneal, our Executive Director, says she just really likes it as an entry point, a way in, to get people aware of hospice because it doesn’t say “hospice”.

LYNE FILIATRAULT: Just to take on a point that you made. And I think it’s something certainly as a physician and not very good, you think about therapeutic care and you think about comfort care and you’re totally right. You’re sometimes both should happen along the same axis together and at some point, palliative takes over because there’s nothing else to offer. And where we see the tragedies is people that have not been referred early on to palliative care. And the family has been coping the best they can. They’re out in the dark. They don’t know how much time is left and all. And I think it’s a failure of physicians and health care in general, of seeing one or the other as opposed to together. And yes, at some point you will become “no intervention” in terms of acute resuscitation. But palliative care was involved from the beginning so that less patients are dropped.

JUDY LETT: And one thing we’re working on right now in Fraser Health is to build capacity for basic palliative care among all front line professionals. And so we have these classes that happen seven times a year. There’s two full day education sessions and we, our focus is primarily on educating the nursing staff. But we feel that if at least we can help to support the basic approaches of symptom management, yes ...

LYNE FILIATRAULT: [?]: Yes. It’s that one. There’s a line there.

TREVOR JANZ: It’s all about cure and gradually it becomes more and more about comfort. We’re all about comfort. So that’s the model. Thank you.

JUDY LETT: Yes, that’s right. And actually you guys in emergency are doing a lot of palliative care. Where do patients come when they’re having symptom crises?

TREVOR JANZ: In a crisis, we’re the default.

JUDY LETT: Yeah, that’s right. Anyways ...

LYNE FILIATRAULT: I think we’re the canary in the coal mine. Like I said, it has to be that we ... it shouldn’t have to be there. We’re not the best environment, particularly the way that we are.

TREVOR JANZ: Yes, we’re the best locators of cracks in the system.

LYNE FILIATRAULT: So if we get this done better outside, before you need us, things are so much smoother and better for everybody. Because we're strangers. Family meets us for the first time and yet they've seen their family doctor or their chronic disease specialist for a long, long time.

JUDY LETT: And people are in crisis. Yeah.

TREVOR JANZ: There is also a benefit to being the stranger. So the family doctor or the specialist can talk to [the patient/family] and it doesn't sink and it doesn't sink in. And I as the emerg doc who hasn't seen you and don't know you from Adam and listen to this story and five minutes say "Holy Smokes. I don't know you from Adam but did you know you're most of the way home? You're about this far from the finish line?" When I listen to all this stuff and that voice from the outside, somebody who doesn't know them at all listens to the story and says and reflects back to them their reality, that's one of the ways that we actually finally break through some of the resistance. This guy doesn't know me and within five minutes he understands my situation completely can tell me exactly where I'm at and he says "Okay, so maybe I need to hear what he's got to say. Maybe I can hear this."

COMMENTOR: Yeah. It's that obvious to a stranger.

TREVOR JANZ: The last [minute?]. Yeah. It's that obvious that yeah. Boom. A stranger can ... and so that occasionally there are advantages to that conversation. And I've got the luxury of working in a small rural emergency department where at night, I recently spent time with a fellow between 2:00 and 4:00 in the morning with a palliative diagnosis that we was in absolute total denial of. And we spent two hours together just talking about that, just sitting there in the dark having that conversation. And he wound up dying three days later. He was absolutely convinced – he was a business venture thing that he was all setting up and he was talking all about what he was going to do next week and what he was planning for next month and this big event he was going to collaborate [on]. It was a prize fight. And his wife was shaking her head and trying to catch my eye. And luckily we had time to just talk about that together and it woke him up.

JILL MCEWEN: So was he grateful for that in the end, that conversation?

TREVOR JANZ: He was enormously grateful and things moved from that point. And [his] wife was so grateful that that had happened. But how often would you guys have two hours at night to talk?

MULTIPLE COMMENTS

COMMENTOR 6 [Leslie Rogers, Fraser Northwest Division of Family Practice]: I just wanted to note in our advance care planning initiative in the Fraser Northwest Division of Family Practice, we're working on the principle that you need, there needs to be seven asks. So that patients need to be asked seven times, seven different people that you're a physician – the specialist, the family doctor – nurses, family. But it's kind of a seven ask thing. So it speaks to, the principle speaks to the notion that we all have a responsibility: the patient – myself as a health care consumer, as a human being, the family, your family physician, your banker, the baker – everybody. There needs to be seven asks because then it makes it real. It makes it part of the conversation and it shows that it is that old adage "It takes a community to raise a child." Well, it takes a community to send somebody on his or her way.

COMMENTOR 4 [Joyce Kuhn, Comox Valley Hospice Society]: When you say seven asks, you referring ...?

COMMENTOR: What do you mean by the asks?

LYNE FILIATRAULT: Judy meant advance care plan.

MULTIPLE COMMENTS

COMMENTOR [Leslie Rodgers]: Are you really going to understand what is going to happen to you?

COMMENTOR: That you're going to die.

COMMENTOR 6 [Leslie Rodgers]: Because often they don't hear what you're saying.

TREVOR JANZ: They would willfully not hear what you're saying.

COMMENTOR 6 [Leslie Rodgers]: I'm also wondering about that term "advance care plan". Does that resonate for most people? Do people understand what that means?

COMMENTOR 2 [Joyce Kuhn]: Not really.

TREVOR JANZ: But as soon as you start explaining it ...

LYNE FILIATRAULT: When you explain it, they get it.

TREVOR JANZ: That's the door ...

COMMENTOR [Leslie Rodgers]: I think they do more and more.

COMMENTOR 4 [Joyce Kuhn]: It gives it an option of being just a conversation or also [a] representation agreement with expressed wishes or advance directive. It doesn't have to be all those. It can be any one of those, so it's just kind of the catch all term.

TREVOR JANZ: It's a conversation. It's a document. It's a ...

JILL MCEWEN: And again, that's not that applicable in the acute care or the emergency setting because we don't have the facts. So we don't know where they are in their [BCHPCA added: journey] unless ... So that's more a conversation for the physician who really knows where they're at. I don't even know if other members of the health care team, unless they're aware of the details, can have that detailed conversation. Because you want to give people hope but at the same time you want to be realistic with them. So percent survival at "x" years is a really good way of telling people – giving them some hope but at the same time they know 75% of people are going to be dead a year from now. So/but I like that seven things [asks].

LYNE FILIATRAULT: We need to get to the point where "a" is not [for] allergy only, it's [for] advance care plan. And I was reflecting in the other sessions, in the [19]80s, it was hard to teach us to ask a sexual history. I remember going "Oh. I have to ask about their sexual orientation and stuff." Now you wouldn't think twice about it. So now we're at the point where we

need to be, get comfortable asking about their plans for end of life. And we need to, ourselves, be comfortable with that question.

TREVOR JANZ: We need to normalize that conversation.

COMMENTOR 6 [Leslie Rodgers]: Dr. Joelle Bradley who is the hospitalist leading the charge on advance care planning in our Division [North Fraser] had initiated a pilot project where she was, she parked herself in Royal Columbian Hospital [New Westminster BC] – a pretty busy tertiary care hospital – on Advance Care Planning Day with a booth. She had buttons “Advance Care Planning Matters”. I’ll wear mine tomorrow. And she approached a physician and health care provider colleagues. And just had the button, had a card asking them a couple of simple questions: “Have you thought about your advance care plan, your desires? Have you talked with your loved ones about it? And are you, will you go forward and have a conversation?” And if people could answer those two questions, they got the button.

So she actually talked to 117 [inaudible] of care providers and that was mostly physicians, specialists – like she was funny. You could just see docs walking down the hall, they just got sucked in. [laughter] They come out with hundreds of buttons. But we did some follow up questionnaire to ascertain how effective this approach might be and we found that a significant percentage – about 47% of the people that she talked to did go home and think about it and communicate their wishes to their loved one. And another significant percentage encouraged others to do so. So it’s again the seven asks. You have to have, there’s so many conversations that need to occur but her hypothesis was that it’s very important, as you’ve been saying, as all the physicians today have been saying, you’ve got to have your own sense of comfort with your own advance care planning desires before you can talk comfortably with patients. And if you’re not comfortable, then you’re probably not going to raise it.

JUDY LETT: Yeah and I think that’s sort of at the crux of the problem for what’s going on with a lot of our specialists. And some of them are older docs really, really struggle with that, so ...

TREVOR JANZ: Denial and avoidance.

COMMENTOR 6 [Leslie Rodgers]: You don’t want to ask a patient the question if it’s not going to be something that you’re not comfortable with. “No, that’s somebody else’s [responsibility]. GPs should be doing that or social workers.” So ...

SHERRY STACKHOUSE: I like how Dr. Edmunds has taken the lead. And there are actually some physicians who are uncomfortable that he wants more patients to be palliative. So there’s some GPs that are not ready in their thinking to use that terminology with their patients. But he’s gradually over the last couple of years really turning the tide with his advocacy.

JILL MCEWEN: Well, I think it goes back to your graph, is that it’s curative and palliative are part, two parts, so it doesn’t have to be one only. So that’s probably an education thing as well. Just labelling someone as palliative means yes, they’re going to eventually die from that disease but it doesn’t mean you can’t offer treatment all the way along.

SHERRY STACKHOUSE: I do think even health care providers today have not always a clear understanding that you can be palliative and we still can be treating you for something. Because I’ll have triage nurses say “Oh they’re a DNR. They’re palliative.” And I’ll say, “Uh-huh. And why are they here?” Because there’s lots of things we can do for people that are palliative. So it’s interesting that I find health care providers also don’t have the same understanding of what we do for people when they come in.

TREVOR JANZ: That's one of the major drawbacks to DNR is that health care providers will very often refuse to treat or fail to treat eminently treatable conditions because you have a "No CPR" order. And we're not doing basic comfort care because you have a "No CPR" order. And this exists as we as health care providers have this problem and how do we approach that because my goodness, it's totally inappropriate for people to not receive comfort care because they're "No CPR." We're truly abandoning these patients.

SHERRY STACKHOUSE: We need to do more of that imaging that they're parallel processes.

JILL MCEWEN: I think it's just a matter of educating the patients and health care workers and ...

TREVOR JANZ: Educating the staff – physicians and nurses.

COMMENTOR 5 [Jeanne Fahlman, Nanaimo Community Hospice Society]: And the public and family.

COMMENTOR: Everybody.

COMMENTOR 5 [Jeanne Fahlman]: Yeah. With our model of palliative care in Nanaimo, it is acute palliative care really. So it is, people come in to have their symptoms managed as well. So we as the hospice – our volunteers, our staff go out and say "Just because you're, you have to put your mother or father in palliative care doesn't mean that's the end. It's, they can come in and they can still come home." So especially someone who is terminally ill, as soon as you say "Well, maybe you should look at palliative care. Maybe we can ..." they get that fear that "Well, this is the end. My time is coming and I can't ..."

TREVOR JANZ: "Palliative care means I'm dying."

COMMENTOR 5 [Jeanne Fahlman]: Yeah. And so we're trying to get that message across too that "Palliative care is still caring for you."

TREVOR JANZ: So call it comfort care? Take the palliative word out?

COMMENTOR 5 [Jeanne Fahlman]: Yeah. Sometimes ...

COMMENTOR 6 [Leslie Rodgers, Fraser Northwest Division of Family Practice]: How about "tweaking"? They're sending them in to get "tweaked". [laughter] And then they can come back out.

MULTIPLE COMMENTS: I like that. They need a "tune up".

COMMENTOR 6 [Leslie Rodgers]. That's what we call the tertiary unit in Burnaby. "We're going to send you to Surrey or Burnaby to get tweaked. And then you can come back."

MULTIPLE COMMENTS: I kind of like that. Nobody ever refuses comfort.

LYNE FILIATRAULT: I kind of like to say "peacocks" [the Palliative Care Team] Comment: Get tweaked by the peacock.

JUDY LETT: “What else do we want? We want to focus on improving your comfort.” Yes. But “You want to be palliative what?” No.

MULTIPLE COMMENTS: Exactly. It’s a loaded word isn’t it?

JUDY LETT: It very much is. And I know people in palliative care have talked about this word for ten, fifteen years – as long as I’ve been involved in it and it always come down [to], it doesn’t matter what you call it because it will have that same connotation.

COMMENTOR [Joyce Kuhn, Comox Valley Hospice Society]: Yeah. That’s probably true isn’t it.

JUDY LETT: So, yeah. I think we need to shift our attitudes around how we look at that instead. Anyways, I think out time is up and I would like to thank all of our speakers for your wisdom, your insight, for sharing your ideas and impressions with us. I have a gift for you, each one of you.

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