Dr. Frank Molnar, President of the Canadian Geriatrics Society; speaking points regarding the Development of a Framework on Palliative Care in Canada

Thank you for this opportunity to contribute to this critical initiative that touches on the lives of all Canadians. As a specialist in Geriatric Medicine I care for seniors in their final years of life. My practice, and the practice of all Geriatricians, is in the years, months and days before a person or their substitute decision maker decides to choose Palliative Care. That lead up to Palliative Care cannot and should not be divorced from Palliative Care – it sets the stage for and creates the foundation for the Palliative Care experience. The experiences preceding the involvement of Palliative Care specialists should be included in the Palliative Care Framework.

I will provide the perspectives from the coal face – the front-lines of physicians working in the community and in hospital with patients reaching the end of their lives.

My focus will be on the training and education needs as well as the measures to support palliative care providers mentioned in Bill C-277. I will list challenges as well as potential solutions for consideration.

**Challenge #1 – Patients and their families are not prepared to engage in Advance Care Planning and Palliative Care discussions.**

It is not realistic to separate Palliative Care from Advance Care Planning as Advance Care Planning sets the stage for Palliative Care. Enhancements to Advance Care Planning should therefore be part of a Palliative Care Framework.

There are excellent existing resources for Advance Care Planning that are evidence-informed (e.g. Speak Up toolkit - [www.advancecareplanning.ca](http://www.advancecareplanning.ca))

Patients and caregivers have told us that they do not know HOW to use the Advance Care Planning resources; they can read the material on Speak Up but they do not know HOW to initiate the conversation – they do not know what to actually say and how to say it. They also find the material is not specific enough – no detailed information regarding common diseases such as dementia, congestive...
heart failure, chronic lung disease to allow them to anticipate and discuss trajectory and expected symptoms. The analogy is as follows: we have the tools (hammers and nails) to build a house but the tools will not build the house on their own – people need to be trained regarding how to use them. It is the same with Advance Care Planning.

**Potential solutions for consideration for inclusion in a Palliative Care Framework.**

1. Include an education strategy regarding HOW to hold Advance Care Planning discussions (these skills will eventually translate into improved skills in holding End of Life discussions).
2. Develop disease-specific modules in Speak Up ([www.advancecareplanning.ca](http://www.advancecareplanning.ca)) relevant to major chronic diseases people die from – dementia, heart failure, chronic lung disease, cancer etc..

**Challenge #2 - Physicians are not prepared to engage in in Advance Care Planning and Palliative Care discussions.**

Physicians are poorly trained in the final stages of diseases – how to recognize them and how to react. Consequently doctors, even specialists, often do not recognize when patients are in their final stages of a disease so they do not initiate or review Advance Care Planning discussions and decisions. In hospital they do not recognize that a patient is dying before their eyes. They wait so long that the person is in their final days before it is recognized – there is no time to organize a plan to die at home.

**Potential solutions for consideration for inclusion in a Palliative Care Framework.**

1. Include an education strategy for health care providers regarding;
   a. The signs that patients are entering the final stages of a disease (The Canadian Geriatrics Society End-Stage heart Failure article can be provided on request as an example of content) to help them recognize signs of the final stages of a disease. This recognition should then trigger new or updated more informed Advance Care Planning discussions. For this to happen we need:
      i. Provincial Advance Care Planning Billing Codes to incentivize MDs to pursue this difficult discussion.
      ii. Online education modules and real time courses to train physicians regarding HOW to hold Advance Care Planning discussion + Canadian College of Family Practice and Royal College of Physicians and Surgeons of Canada accreditation for these courses

**Challenge #3 - inadequate training in Palliative Care for Health Care Providers caring for dying patients.**

In-hospital most physicians and nurses are not trained to provide palliative care and consequently they use the wrong medications and/or use doses that are too low for “fear of hastening death” resulting in unnecessary suffering. Many hospitals have no Palliative Care Services. Even when a Palliative Care service is available it is not available on weekends
Potential solutions for consideration for inclusion in a Palliative Care Framework.

In-hospital

1. Copy Cardiac Life Support approach
   a. We have Basic Cardiac Life Support (CPR) and Advanced Cardiac Life Support (drugs, intubation etc.). Can we have **Basic Palliative Care** for first hours / days until the Palliative Care team can come to provide Advanced Palliative Care?
   b. Can we demand that every Physician and RN who cares for patients at risk of dying is certified in Basic Palliative Care
      i. If this is not possible then can we ask that every service / ward that cares for patients at risk of dying have a pre-specified number (to insure 24/7 coverage) of Palliative Care Champions certified in Basic Palliative Care
   c. Can we ask the Royal College of Physicians and Surgeons of Canada to integrate the need for Basic Palliative Care certification in the training requirements of all specialists who will practice in fields where they will care for patients who are at risk of dying

2. Copy protocols used in hospital (e.g. pain protocols, bowel protocols)
   a. Develop **Basic Palliative Care protocols** – common drugs to start (perhaps tailored to the disease) with appropriate doses to overcome lack of knowledge of what medications to use and reluctance to use higher doses for fear of hastening death.

In-general

1. Develop online education modules and real time courses to train graduated practicing physicians regarding how to provide Basic Palliative Care
   b. For this to happen we need Canadian College of Family Practice and Royal College of Physicians and Surgeons of Canada accreditation for these courses leading to a **Basic Palliative Care certification**

Nothing replaces the Advanced Palliative Care that Palliative Care Teams bring. Their critical contributions go far beyond medications – they include the compassion, knowledge, wisdom and experience of the teams that is reflected in their interactions as they communicate realities with patients and families, counsel them and support them. The Palliative Care Teams also provide invaluable help and support to all medical and surgical teams as they emotionally struggle with the deaths of the patients under their care (i.e. consider that there may also be suffering on the part of the health care providers). The measures above are designed to insure some Basic Palliative Care is provided while waiting for the Palliative Care Team to arrive as well as to insure the Palliative Care Team has capable partners to work with. This will extend and enhance the impact of Palliative care teams.

Respectfully submitted

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