It takes a village to say goodbye.

Dr. Greg Andreas

10 July 2025 | 0800-0900

THE UNIVERSITY OF BRITISH COLUMBIA
Continuing Professional Development
Faculty of Medicine

LAND ACKNOWLEDGMENT

We acknowledge that we work on the traditional, ancestral and unceded territory of the Skwxwú7mesh (Squamish), xʷməθkwəy̓əm (Musqueam), and Sə̓lílwətaʔ/Selilwitulh (Tsleil-Waututh) Nations.

I share with you from the ancestral and unceded territory of the Ktunaxa Nation.

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PRESENTER DISCLOSURES

I receive funding for a Shared Care project;

”Curiosity, Frailty and Palliative Care”

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STATEMENT OF INTENT

- I believe our time together will add value to the Shared Care project's intention of bringing meaning and dignity to our final chapters of life.
- I will be grateful for feedback that can further this work.

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LEARNING OBJECTIVES

Through cases, stories and questions;

- Recognize death as a part of life.
- Identify barriers and opportunities to optimize living until we die.
- Demonstrate the strategy of What Matters To You (WMTY) to humanize healthcare and optimize each other's lives.
- Empower and challenge you in spreading this culture shift.

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POLL QUESTION

Should we live / die primarily as a person or a patient?

1) Person?
2) Patient?

Please share in the chat. About this. Your thoughts.

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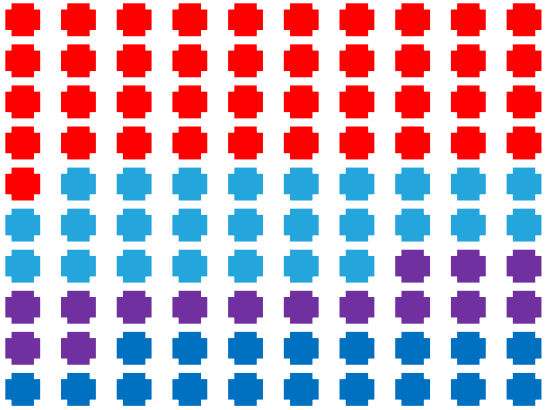
Context

- 66% of BC Cancer patients received 1st palliative care code on final admission

- 62% of Canadians who received palliative care did so in an acute care hospital in their last month of life

- More Patients die in Acute Care than anywhere else

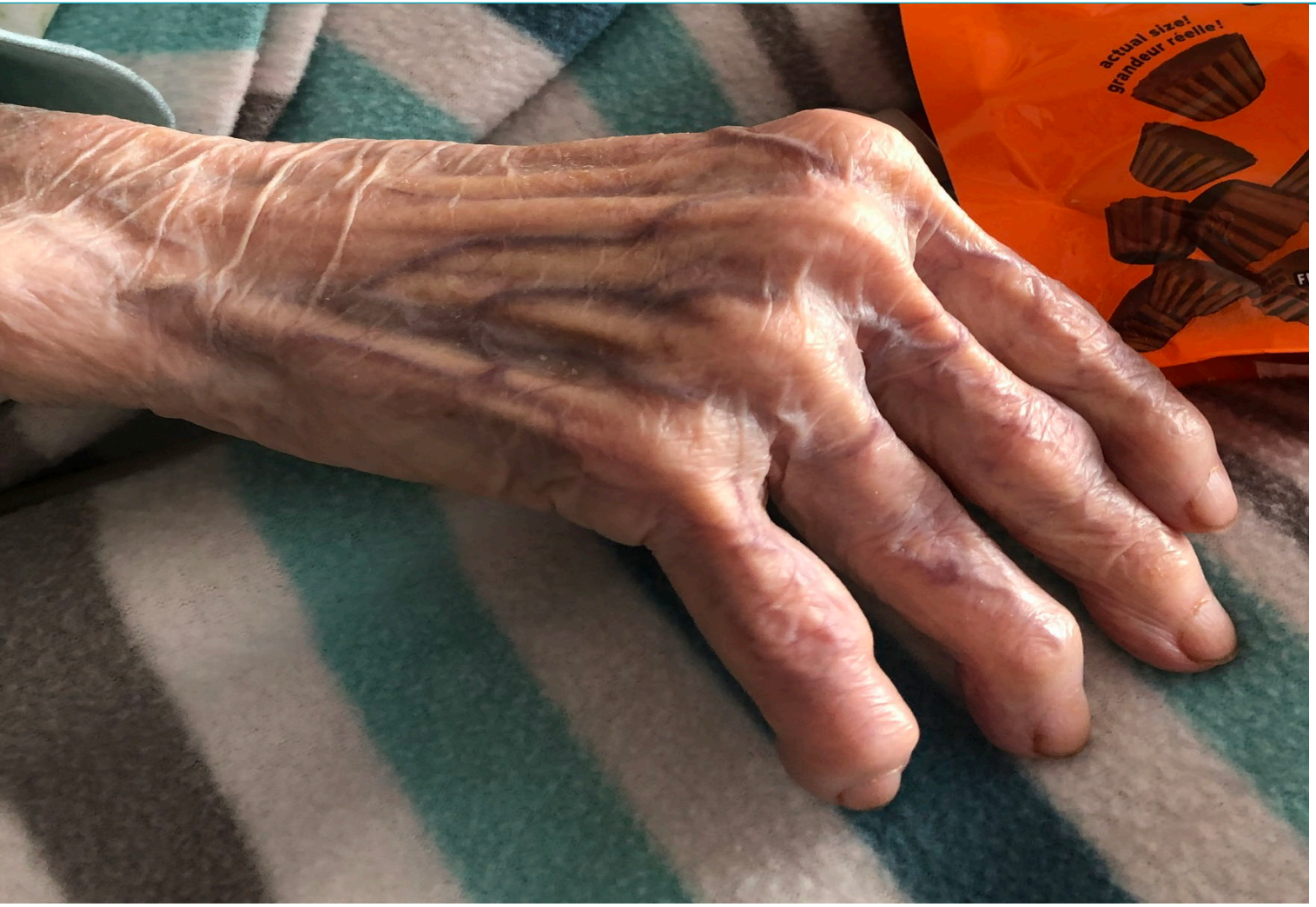
Acute Care 41%
Long Term Care 25%
Hospice 15%
Home 18% (note that US is 29%)



Palliative Data set project Ministry of Health
JCO: March 2017: Decaria, Dudgeon et al
CPAC: Person-Centred Perspective Indicators: 03/2017
CIHI 2018

CASE #1

WHAT MATTERED TO MARY?



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OVERVIEW

- Mary, very frail in LTC for 2 years
- Living a decade with advancing dementia. Now severe.
- Eating poorly. Decreased language. MOST M2
- Slid out of her wheelchair. Pain, left hip, short leg int rotated.

- She is on the floor. Early on a Saturday morning.

- What happened next?

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WHERE ARE YOU ON HERE?

HOW CAN WE HELP EACH OTHER?

Clinical Frailty Scale*

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 **Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 **Managing Well** – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 **Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 **Mildly Frail** – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People need help with **all outside activities** and with **keeping house.** Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 **Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. **Terminally Ill** - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

DALHOUSIE UNIVERSITY *Inspiring Minds*

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What Matters To You?
WMTY

CASE #2... ALICE

...and her husband gave me something....

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OVERVIEW

- They shared their currency… their lived experience.
- Both were in their 80s.
- I had requested they do ACP & MOST.
- It was part of my QI project…
- I was their family doctor…

- It was hard getting “patients” to do this work!

- Alice suggested a very different approach/ marketing!

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ALICE… PROGRESSION

” Talk about living because we die at the end of living…”

What I am learning:

- Connect, “hug”, acknowledge, walk next to, listen, listen, listen.
- Who is this person? WMT, this person?
- Your next question is from your curiosity about what you are hearing. Listen for what will reveal her best story/ path.
- … Person before paperwork.

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WHAT ARE YOUR GOALS FOR THE REST OF 2025?

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GROW Framework

STRATEGYPUNK

	**Goal**	What do you want to achieve?
		• Definition of goal: How will you know you achieved this goal? • Make sure that the goal is SMART: Specific, Measurable, Attainable, Realistic, and Time-bound.
	**Reality**	Where are you now?
		• What is happening now - what, who, when and how often? • Fully consider the starting point. What resources do you have to help you?
	**Options**	What could you do?
		• What are potential obstacles in the way? • Which options could bridge the gap from reality to goal? • Which obstacles are stopping you from getting where you want to be?
	**Will**	What is the plan? What will you do now?
		• Commit to specific actions in order to move towards the goal (action plan). • Decide on a date when you review the progress in order to provide some accountability.

Serious Illness Conversation Guide

CONVERSATION FLOW	PATIENT-TESTED LANGUAGE
1. ***Set up the conversation*** · Introduce purpose · Prepare for future decisions · Ask permission	"I'd like to talk about what is ahead with your illness and do some thinking in advance about what is important to you so that I can make sure we provide you with the care you want — **is this okay?**"
2. ***Assess understanding and preferences***	"What is your **understanding** now of where you are with your illness?" "How much **information** about what is likely to be ahead with your illness would you like from me?"
3. ***Share prognosis*** · Share prognosis · Frame as a "wish... "hope...worry" state · Allow silence, explore emot	"...share with you **my understanding** of where things are with your illness..." *Typical:* "It can be difficult to predict what will happen with your illness. I **hope** you will continue to live well for ...e but I'm **worried** that you could get sick quickly, and I think it is important to prepare for that possibility." *Ti... wish* ...were not in this situation, but I am **worried** that time may be as short as ___ *(express as a range, ...days to ...weeks, weeks to months, months to a year).*" Or *Function:* "I ...pe t... this is not the case, but I'm **worried** that this may be as strong as you will feel, and things are likely to get ...more difficu...
4. ***Explore key topics*** · Goals · Fears and worries · Sources of strength · Critical abilities · Tradeoffs · Family	"What a... yo... m... important **goals** if your health situation worsens?" "What are your ... **and worries** about the future with your health?" "What give... **st**... ...think about the future with your illness?" "What **abilities** are ... ...life that you can't imagine living without them?" "If you become sick ... ...**e you willing to go through** for the possibility of gaining more time?" "How much does yo... ...family know about your priorities and wishes?"
5. ***Close the conversation*** · Summarize · Make a recommendation · Check in with patient · Affirm commitment	"I've heard you say that ___ is really important to you. Keeping that in mind, and what we know about your illness, I **recommend** that we ___. This will help us make sure that your treatment plans reflect what's important to you." "How does this plan seem to you?" "I will do everything I can to help you through this."
6. ***Document your conversation***	
7. ***Communicate with key clinicians***	

ARIADNE LABS

POLL QUESTION

What does “palliative” mean to you?

What could “palliative” mean to others?

Please share in the chat.

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BARRIERS INTO OPPORTUNITIES

What I am learning:

- Trauma-informed care… “palliative”
- Give away the agenda… what you get back could surprise.
- “Truth telling”… vs curious truth listening/ feeling.
- “Time”… who has less?
- Connect with the person… living with…
- How can we look at “difficult conversations”?

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CASE #3: WE DESIGN OUR VILLAGE

- How can we walk next to someone who needs us there?
- How do we make it safe to show up? Hierarchy?
- What is the role of curious vulnerability?
- How could “knowing/ educating” cause hurt?
- What is our opportunity to connect when we let go…?
- What culture and strategy do we need to support us?

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CASE, STORY #4...

… his foot was gangrenous.

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“WE ARE JUST WALKING EACH OTHER HOME.”
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RESEARCH AND RESOURCES

- Hip: http://bit.ly/4nwBjdv
- WMTY: http://bit.ly/45SA0zk
- GROW MODEL: https://bit.ly/JohnWhitmore_racingdriver
- Dame Cecile Saunders: http://bit.ly/4ntOpYY
- About Failure: https://bit.ly/4ItDcq9
- SICG: http://bit.ly/3TXO0Ak
- Doctors of BC frailty policy: http://bit.ly/3IbXLbG
- Jennifer Temel: http://bit.ly/46nojAG

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