



Cardus – Pallium Roundtable



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CARDUS — PALLIUM ROUNDTABLE

Introduction

On April 27, Cardus, in partnership with Pallium Canada, convened an expert multi-disciplinary roundtable focused on the delivery of palliative care in Canada. Approximately a quarter of the participants were palliative care doctors and experts, while the others included a diverse group of community organizers, academics, policy implementers, and innovators. (See Appendix A for the biographies of participants.)

The objective of this roundtable was to leverage a diverse set of experiences and expertise in order to better understand how best to adopt, adapt, and engage communities in a public health palliative-care (PHPC) strategy. Recognizing that a PHPC strategy includes holistic, compassionate, patient-centered, family-focused, and community-based palliative care, the roundtable sought to better understand what this “palliative care landscape” encompasses through the eyes of various experts.

Since the 1995 Special Senate Committee on Euthanasia and Assisted Suicide recommended that “governments make palliative care programs a top priority in the restructuring of the health care system,” subsequent reports have constantly reaffirmed the importance of making this a top priority. However, palliative care remains inaccessible to approximately 70 percent of Canadians.

It is not that the issue has been ignored. The agenda document summarized various models, including the internationally recognized “Compassionate Communities” model, which has been promoted in Canada. Various groups with a desire to help Canadians die well have initiated good work; nevertheless, strategic questions remain about how to coordinate the efforts of various organizations and community players in delivering the best of palliative care, and how to catalyze frontline impact. Cardus and Pallium Canada put these questions, and others, to the Palliative Care Roundtable. This report provides a summary of the key themes that participants identified in their discussions.

Care around death and dying is often thought to be a subset of the medical system. However, the steps needed to improve care are as much a matter of culture as they are of health. This was the case with smoking cessation, retirement saving, or even household recycling. Each became larger societal projects when they became embedded into the cultural consciousness. Likewise, we need a cultural shift in order to die well. Dr. Denise Marshall from McMaster, roundtable participant and long-time champion of the “Compassionate Communities” framework, summarized it well:

Our society is not against death, but against dying. We are a dying-denying society; we want death without dying.

Of course, a roundtable discussion and a document summarizing themes does not constitute a culture-changing exercise, but they can be a valuable resource for framing a way of thinking about the issue and indicating possible next steps that might prompt real change. We hope our work on April 27 might have such a legacy.

Ray Pennings Roundtable
Facilitator
Cardus Executive Vice-President

SUMMARY OF THEMES

The Community Lens— Catalyzing Connections

Canadian communities are diverse - not only in terms of geography and culture, but also in terms of their diverse capacities and access to care. Moreover, communities, and the families within them, have varying abilities to mobilize around palliative care. Therefore, one participant explains, the current need is “to ground the approach in the real values and experiences of people within the community.”

The term “palliative care” is differently understood by various communities. The World Health Organization defines the term as “an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual.” However, for most participants, palliative care is most commonly understood to be the medical care provided when death is imminent. The necessity of finding appropriate language was a theme that recurred throughout the discussion – both as it related to various subthemes and details but also relating to the term that is at the center of the conversation, palliative care. “Natural death,” “good death,” and “dying well” are among the terms that different participants used with both support and critique from others.

Various participants underscored the centrality of understanding the community as an essential part of any public health palliative care strategy. Diverse communities have diverse capabilities, and a palliative care strategy involving the community must assess the community’s “readiness” or “capacity.” Yet this is complex. One participant asked, “What aspects or conditions are to be considered in assessing community readiness?” Are we referring to physical infrastructure, policy frameworks, a culture of strong collaboration, strong local leadership, etc, or all of the above? Which of these are key to understanding the community’s capacity to mobilize around palliative care? Another participant offered a series of related questions: “What is the capacity within the family and the community to support this kind of model? Is there a limit to this? And what might the evidence be in this regard?”

The language of connectivity, relationships, networks, social capital, etc., and the notion that we must “join up and across” in order to tackle issues that are multifaceted and complex is also central to the day’s discussion. “How do we galvanize the efforts of young people who want to take care of one another and the planet so that disparate parts can be joined up?” asked one participant. “How do we catalyze the connections needed to mobilize and support people in communities?” asked another. “How do we support and enable the 80 percent of care that is non-formal?” asked a third.

A central question, then, is how do we go about making choices about connectivity? Are there **key relationships** needed in all communities, regardless of their respective differences? Is there perhaps a need to build circles of care involving primary, secondary, and tertiary relationships? Or perhaps, as one participant asks, does this require “building supports of low, medium, and high complexity?” And what of the community? Does the nature of these patterns depend on the nature of the community itself? How do we go about understanding the key areas of potential cooperation within communities? How do we assess the kind of intervention that is most effective for a particular place? In general, then, how do we make choices around where to make key investments in terms of “joining up and across” for any given community?

The theme of **connectivity** was central to discussions throughout the day, but the challenge remains to give shape to these broad deliberations, to find patterns in order to help move the conversation forward. To this end, it is helpful to consider the underlying motivations of participants as they offered their thoughts on barriers and suggestions for how best to mobilize change. In this analysis, one finds two general lines of thinking among participants: the first around culturally driven change; the second around institutional or governance related change. While in practice there is overlap between these two “theories of change,” our summary is organized along these lines.

Social Architecture and Culturally Driven Change

Discussions on end-of-life care have risen to the forefront of policy discussions in recent months as parliamentarians debate the details of Bill C-14. But these legal and policy discussions occur against the backdrop of a shifting cultural debate with strong ethical and moral dimensions. There is strong sentiment among participants that a public-health palliative-care strategy depends not merely on institutional change, but also on a **culture of care** for the dying. As one participant explained, “The cultural dimensions of change are integral [...] and can almost be considered as the sixth dimension of the Ottawa Health Charter.”

The focus of much of the discussion was on the importance of **engaging the public** on palliative-care. “Cultural engagement is really encouraging,” remarked one participant, as a means of “opening people’s hearts and touching people’s minds.” Moreover, added another participant, “there is a certain readiness in Canadian culture around connectedness, social relatedness, and community at the same time as there is a growing awareness that individualism is misleading us.” There is importance, explained the participant, “in paying attention to cultural receptivity and the different aspects of culture, as people are waiting to become part of something bigger than themselves.”

Another participant commented on the **importance and strength of stories**, as a means of influencing major change. Stories have the capacity of **transmitting values**, which then motivate change – a process the participant referred to as “value-based transformation.” The sharing of end-of-life journeys can play an integral role, therefore, in motivating culturally driven change, and perhaps provide somewhat of an antidote to a society that has for the most part effectively set apart and institutionalized suffering.

Beyond sharing values, stories also have the added benefit of describing how one makes sense of, and finds meaning in, end-of-life experiences. As one participant clarified, there is an important **distinction between pain and suffering**: “Existential suffering,” he explained, “allows for a deeper discernment about human fragility and meaning [...] as well as an understanding of our deeply relational and interdependent nature.” “Death,” he eloquently added “is a great teacher as it shows us how much we need.”

Though conversations on culturally driven change and the role of culture were broad in nature, two central and connected themes emerged: the first theme concerned **the power of collective actions**, or “movements”; and the second theme concerned **the need to consider “language.”**

A) We Need a Revolution!...Or Maybe Just a Movement

“How do we nurture a palliative-care movement?” asked one participant. A movement, he explains, “galvanizes a critical mass that then creates cultural receptivity.” When this is not paid attention to, he continued, “there is a need to essentially back-fill what has been scaled up.” A movement, or collective action, has **the power to transform social norms**, which then makes it easier for the political system to get involved. “Cultural receptivity is therefore integral to political receptivity,” the participant explained. Indeed, the need to create a public moment, a movement, or some **catalyst for change** was noted by various participants and inspired much interest, but also provoked a host of questions around how best to nurture these efforts and spaces.

B) Let’s Talk About Language

There was broad agreement among participants on the need to consider the language around palliative care. The general public has little knowledge or understanding of palliative care, explained one participant, and palliative care language needs to be translated so that people within the community can understand the relationship between their own caring activities and palliative care. “We need to make the language more understood and effective in helping to mobilize community.”

Other participants had different reasons for stressing language: “There is need for conceptual clarity of medical aspects,” remarked one participant. While another declared that “there is a need to reclaim language about choice, comfort, and dignity.” A third postulated that “it would be helpful to create a small vocabulary that is previously agreed upon by our partners in order to advocate for change.”

The need to consider language was a consistent theme throughout the discussion, including language that references mobilizing a community links to the questions of culture.

Institutional Change and Governance

While the themes of culture, movements, and language were central to the roundtable discussion, there was little doubt that institutional supports are integral to providing capacity for moving forward in a coordinated and unified manner. “Embedding palliative care in the community involves a shift from the present day siloed approach to one that is coordinated and collaborative” explained one participant. But most around the table knew well that there are important challenges here, since the culture of the healthcare bureaucracy is slow or resistant to change.

Moreover, while there is need for horizontal coordination, there is also the need, as one participant noted, for vertical coordination. At present there are no standards around access to care, funding, resources, etc. Therefore, there is a need for leadership in terms of either coordinating these efforts or pushing for a national strategy on these fronts. On this point, a participant offered that “one of the most powerful ways to influence government is to give governments the help they need in order to pursue an agenda.” Government officials are very busy and often lack capacity. “We should be embarking on intelligence gathering,” added another participant, “on where we think the provinces and feds are going, because this can feed back into our efforts.” Another participant shared that a group of lawyers are mobilizing around the notion of palliative care as a right. Some suggested the need for a “National Strategy for Palliative Care” while others cautioned that government-focused initiatives are limited in their effect. Several voices also pointed to the education curriculum changes as key to developing a life-long awareness of these issues. There was no lack of ideas, but implementation depends on leadership, convening, and coordination.

Moving Forward

Late in the day, a participant asked: “Is this about positioning yourself within a paradigm or about shifting the paradigm?” The question relates to “theories of change.”

If we are to pursue a public health palliative care strategy across communities in Canada, what would these efforts look like? Would it seek to create a culture of care for the dying, a movement around the dignity of life as it nears its end or around compassionate communities that value caregiving and its vulnerable members; or would efforts be geared at bringing together and integrating different service providers and governance institutions? Though there is much overlap among these important questions, where do we draw lines and how do we decipher what kinds of investments and interventions are needed for particular and diverse communities? How do we define and gauge cultural and political receptivity across communities? Most fundamentally, as one participant asked, “how do we decipher the appropriate catalytic role that is needed to join up what already exists?”

Roundtable discussions were spirited throughout the day; perhaps motivated by new-found synergies, ideas, and connectivity which leads to creativity. Our capacity for action rests in our capacity to come together and learn from one another with a spirit of openness and hope.

The palliative care framework in Canada is, at present, fractured and sporadic, with no real standard in terms of funding, access, and governance mechanism. This environment is one that can lead to a culture of mistrust and insecurity among healthcare and service providers, but it is also ripe for innovation and collaboration. We must make the right choice.

It is now time to capture the lessons from a proliferation of promising practices across Canada in order to better understand our way forward. Our ability to work together in a unified and coordinated manner rests on our ability to understand “the universalities” amidst the “differences,” as one participant so eloquently stated, and this can only come through a comparative analysis of patterns and relationships across these various promising practices. The analysis should seek to understand initiatives *as well as* places, with an understanding that the two are connected and that prospects for scalability depend on an understanding of this central relationship. The analysis would allow us to better understand key aspects, conditions, and relationships in order to help us better decipher **community readiness and capacity**, the **appropriate catalysts** or **needed investments** for a particular community, and the conditions that are essential for supporting wider and deeper networks of care within community.

Next Steps/Recommendations

The Canadian culture has morphed over time: realities once taken for granted—they simply “happened”—have become matters of conscious and deliberate focus, planning, and preparation. Consider the changes regarding preparation for birth and the process of receiving a child into a family. Today, even if some people choose not to follow through, it is taken as a given that first-time parents prepare for their child’s arrival with pre-natal classes and a birth plan. While in the prime of our working years, prompts come from all around us to prepare for retirement years by saving. We may not have the RRSPs in our account that we wish we did, but it is a matter of conscious thought.

Similarly, we confront the need to document how our material assets should be distributed after our passing, so we have (or feel guilty about not having) a current will.

The time is ripe for similar preparation to take place regarding the dying process. Advanced Care Planning is not simply a one-time “talk” with the doctor regarding the extent of heroic interventions that we might desire; it needs to be an ongoing process in which we plan and make the choices that equip us to die well. Certainly, some of the process has to do with medical care, but much of it involves the non-medical aspects and preparations for the end of life. We already recognize (and must further develop) the formal supports that come from being a part of a society with various institutions. We need to do better at identifying and supporting the informal care relationships on which we rely.

Cultural change does not “just happen” and is not the responsibility of any one sphere of society. Emerging from our roundtable conversation were not only the themes of the day summarized by this document, but also an appetite to evolve the conversation, perhaps by replicating it at a local level in various places across the country. The discussion could thus be more specific and particular. We could identify and recruit specific players of a local context to participate and focus on the synergies and barriers at the local level. After convening these discussions in a few different areas of the country, comparing notes, and learning from best practices, perhaps the beginnings of a framework “asset map” might result. This map would link into the conversation players whose participation is crucial for the culture-changing success we desire, yet who might not today even be aware of their potential for contribution.

CARDUS—PALLIUM CANADA ROUNDTABLE

Hosts

Dr. Kathryn Downer

Kathryn Downer, MSc, EdD, is the National Director of PalliumCanada. She is currently responsible for the design and development of interprofessional educational courseware, tools and resources to support palliative care community capacity building across urban and rural Canada. The foundational Learning Essential Approaches to Palliative and End-of-Life Care (LEAP) courseware and the Pallium Palliative Pocketbook 2nd Ed. (available in both languages) provide nationally standardized, competency based, peer-reviewed continuing professional development and medical undergraduate /resident training in palliative care essentials customized to many care settings. The Pallium App provides regional, provincial and national access to tools and resources. Dr. Downer's work includes catalyzing palliative care Compassionate Communities (CC) by modelling a CC National Community of Practice promoting Compassionate corporations, schools and neighbourhoods/communities. She holds a Doctorate in Adult Education specializing in Gerontology from the University of Toronto, a Master's of Science, University of Guelph, and Certificates in Ethics, Resident Assessment Instrument for Home Care (RAI-CHA), Non-Profit Management, Hospice Palliative Care, Interpersonal Skills Involving Seniors (ISIS) and Learning Essential Approaches to Palliative and End-of-Life Care (LEAP). She is a member of the Quality End of Life Care Coalition of Canada (QELCCC), Co-Chair of the QELCCC Education Committee, Canadian Frailty Network Training and Education Committee, Canadian Partnership Against Cancer National Network, and Hospice Palliative Care Ontario Standards Council.

Mr. Ray Pennings

Ray Pennings, BA, MA, is a co-founder of Cardus and currently serves as its Executive Vice President, working out of the Ottawa office. He has long experience in Canadian industrial relations, as well as public policy, political activism, and political affairs generally. He is the author of "Death is Natural" and has headed the Cardus Health Initiative. Over the years, he has headed several of Cardus' largest research projects, including a monumental education survey that led to the Cardus Religious Schools Initiative in association with the University of Notre Dame. Ray is a respected voice in Canadian politics as well, having held senior positions on campaign teams at municipal, provincial, and federal levels. Ray did his under-graduate at McMaster University and holds a Masters of Arts in Religion from Puritan Theological Seminary. Ray's grasp of applied public theology is evident through his writings (much of which can be found at cardus.ca) but also through his volunteer efforts. He has served on the boards of charities, universities, community groups and in his church community, including present commitments on the boards of the Rosebud School of the Arts and the Civitas Society.

Dr. José Pereira

José Pereira, MBChB, CCFP, MSc, is co-founder and Scientific Officer of PalliumCanada. He led the development of the Learning Essential Approaches to Palliative and End-of-Life Care (LEAP) as well as the Pallium Palliative Pocketbook and Palliumapp to support primary-level palliative care. Dr. Pereira is also a Palliative Care Physician at the William Osler Hospital in Brampton and Full Professor at the University of Ottawa. He recently became Director of Research at the College of Family Physicians of Canada. Dr. Pereira's work has encompassed health systems, clinical studies and education that aim to improve Palliative and End-of-Life Care and access to these services. He has published broadly in peer-reviewed journals and is recognized nationally and internationally for his contributions to palliative and end-of-life care. In 2002 and 2012 he received the Queen Elizabeth II Gold and Diamond Jubilee Medals for his contributions to Palliative Care in Canada.

Participants

Dr. Caroline Andrew

Caroline Andrew, BA, M.Sc. Soc., PhD, OC, is a Professor Emeritus and Director of the Centre on Governance at the University of Ottawa, and was dean of the Faculty of Social Sciences from 1997 to 2005. A political scientist by training, her research interests center around the functioning of partnerships that bring together community-based equity seeking groups, local social service delivery agencies, municipal governments and university based researchers. Current projects include the Council on Aging, working with Age-Friendly Ottawa, the City for All Women Initiative, the City of Ottawa Equity and Inclusion Lens, and Youth Futures, an initiative in partnership with the City of Ottawa, the Ottawa post-secondary sector and multiple community partners to promote postsecondary education with high-school students most distanced from opportunity. She is a member of the Executive Committee of the Ottawa Local Immigration Partnership and member of the Board of the Catholic Centre for Immigrants. She is a nationally recognized authority on urban and feminist studies, as well as on cultural diversity. She became a member of the Order of Canada in 2015.

Dr. Doris Barwich

Doris Barwich, MD, CCFP is the Executive Director of the BCCentre for Palliative Care (BCCPC) of the Institute for Health System Transformation & Sustainability (IHSTS). She has established the Centre's strategic focus and mobilized provincial networks and partnerships. Prior to joining the Centre in 2013, she co-lead, as Program Medical Director, Fraser Health's End of Life Care program with several nationally and internationally recognized leading practices in Advance Care Planning, population health and program-delivery. Doris has served on numerous provincial and national Committees and Boards, including as President of the Canadian Society of Palliative Care Physicians (CSPCP), and has been part of developing innovative approaches to improve care for patients and families living with serious illness. She is a member of Canadian Researchers at End of Life (CARENET) developing tools and resources for Advance Care Planning. Recognized for her advocacy and leadership on a variety of provincial and national palliative/end of life care initiatives, she is passionate about supporting transformative changes within the health care system and in society as a whole as we all embrace the challenges and opportunities of living and dying well in the 21st century.

Mr. Mark Bell

Mark Bell, BA (Honours, Communication), BEd, MA, is Senior Advisor, Government and Corporate Relations for Pallium Canada. He has taught at the University of Ottawa's Department of Communications and Algonquin College's Business Management Program. He served as a member of Transport Canada's task force establishing the Canadian Aviation Safety Board (now known as the Transportation Safety Board), and later served with the Transportation Safety Board Review Commission, and the Postal Services Review Commission. He has also worked with Canada Post integrating innovation systems within the corporation's strategic plan, and with the Department of National Defence auditing departmental communications operations within federal government communication guidelines.

Ms. Vickie Cammack

Vickie Cammack, OC, is the founding director of Tyze Personal Networks, a pioneering Canadian social enterprise that delivers online networks of care for people facing life challenges. She is a social entrepreneur who has established many groundbreaking organizations dedicated to strengthening community and addressing isolation including Planned Lifetime Advocacy Network (PLAN, with her husband, roundtable participant Al Etmanski) and the Family Support Institute of British Columbia. Vickie's unique response to the isolation and loneliness that underpins some of our most intractable social

problems—a network model of care—has been adopted internationally. Following on her work with PLAN, to secure financial independence for people living with a disability well into older age, was the development of the Registered Disability Savings Plan, which was championed into being by the late Canadian Finance Minister, Jim Flaherty. She co-led a Canadian exploration on sustainability and social innovation, and is a Fellow with Social Innovation Generation, a partnership between the University of Waterloo, MaRS, and J.W. McConnell Family Foundation. She became a member of the Order of Canada in 2015.

Ms. Rosario Cartagena

Rosario Cartagena, BSc, MSc, JD, is a member of the Health Law Group at Fasken Martineau DuMoulin LLP. She provides advice on a variety of health law matters, including corporate governance, public policy, government relations, risk management, privacy, health regulatory compliance, and health research. She also regularly assists in drafting agreements related to corporate governance and regulatory compliance across the health sector. In the past year, she organized a conference on Physician-Assisted Death in Canada in partnership with Health Law in Canada, the Institute of Health Policy, Management and Evaluation, University of Toronto, the Canadian Medical Association, the Ontario Hospital Association, the Ontario Medical Association, the Registered Nurses Association of Ontario, Cancer Care Ontario and certain experts. As Deputy Editor-in-Chief of Health Law in Canada she published a special edition of the Journal on Physician-Assisted Death in Winter 2016. Further, she was most recently awarded a grant by the Law Commission of Ontario to study the impact of “Suffering for Decision-Making and Methods of Assessing Capacity in the Last Stages of Life.” Lastly, she has been advising the Centre for Effective Practice, an organization retained by the Ministry of Health and Long-Term Care to develop a tool for physicians to better understand the parameters for physician-assisted dying in Ontario.

Dr. Claudia Chowaniec

Claudia Chowaniec, PhD, CMC, President of Precept Inc., has more than 30 years’ experience in Canada and the United States as an adviser, coach and consultant in the field of strategic, business and human resource planning, management development and governance practices. She applies socio-technical design to large systems change and introduces participative approaches to productivity and performance improvement. She has served as a director, advisor, facilitator, and fundraiser for many community-based organizations, including the National Capital Commission, YMCA-YWCA Board and Strategy Planning Committee, the Canadian Museum of Nature, and the Ottawa Art Gallery. Claudia served as the 2002 Chair of the Greater Ottawa Chamber of Commerce. She was also a member of the Citizens’ Panel on Local Government Restructuring. Claudia was educated at Queen’s and York Universities and holds a Ph.D. from the University of Leeds in Great Britain. In 2013 Claudia published, *Memoir of Mourning: journey through grief and loss to renewal*. Her interest in palliative care and hospice services has led her to undertaking speaking engagements, designing and facilitating workshops, and planning training opportunities to encourage and support people to share their own stories of grief and loss and in that sharing find solace. She has been invited to join the planning team for the PHPC 2017 International Conference to help bring the voice of the health care consumer to the conference.

Mr. Al Etmanski

Al Etmanski, OC, is a community organizer, social entrepreneur and author. His latest book, *Impact: Six Patterns to Spread Your Social Innovation*, is a Canadian bestseller. He is co-founder of Social Innovation Generation (SiG) and BC Partners for Social Impact. As co-founder of Planned Lifetime Advocacy Network (PLAN) he proposed and led the campaign to establish the world’s only disability savings plan—the RDSP. He is an Ashoka fellow and a faculty member of John McKnight’s Asset-Based Community Development Institute. He was recently awarded the Order of Canada (along with his wife Vickie Cammack) and the Order of BC. Al blogs at www.aletmanski.com.

Dr. Konrad Fassbender

Konrad Fassbender is the Scientific Director for Covenant Health Palliative Institute and an Assistant Professor in the Division of Palliative Care Medicine at the University of Alberta. Konrad holds cross-appointments as Adjunct Assistant Professor in the School of Public Health and Fellow of the Institute of Public Economics. His program of research concentrates on the effects of health reform and technological change on health and economic outcomes of dying patients and their families. He supervises medical trainees and graduate students, and teaches health economics, health finance plus econometrics. Konrad collaborates with academics, clinicians, administrators and policy makers to measure cost and performance associated with the financing and delivery of health care and social services. His areas of expertise are Health Economics, Economic Evaluation, Health Services Research, Large Administrative Datasets, and Palliative & End of life Care.

Mr. Kyle Ferguson

Kyle Ferguson is the Advisor for Ecclesial and Interfaith Relations for the Canadian Conference of Catholic Bishops.

Hon. Dave Hancock

Dave Hancock, QC, was the 15th Premier of Alberta in 2014. He served as a member of the Alberta Legislature for seventeen years. As a social policy architect, he created new energy and discussion around the structure and operation of innovation in Alberta and the roles of the government, industry and post-secondary in development and commercialization of innovative products in five main sectors: Oil & Gas, Agriculture, Forestry, Information Technology and Biosciences and Life sciences. He worked with leaders in the innovation sector including innovation financing. He led the creation of the Human Services department in government bringing together two major departments and portions of three others to focus on service delivery and achieving outcomes in all areas relating to children, families and the human condition including jobs, labour and immigration. He created a leading edge consultative process engaging over 35,000 Albertans in creating Alberta's Social Policy Framework. He also led a complete review of Education in Alberta and thorough engagement process resulting in Inspiring Education, a new education policy for educating Albertans over 30 years and resulting in a complete rewrite of Legislation through a new Education Act. He promoted development of Primary Care Networks as a model of comprehensive multi-disciplinary support for Albertans to stay healthy and manage chronic conditions.

Dr. Mary Lou Kelley

Mary Lou Kelley, MSW, PhD, is a Professor Emeritus in the School of Social Work at Lakehead University and a part time professor at the Northern Ontario School of Medicine in Thunder Bay, Ontario. Dr. Kelley's research and many publications focus on improving health and social services for older adults, rural health, Indigenous health, long-term care policy and delivery, palliative care, and interdisciplinary gerontology education, including for health care professionals. Her research on community capacity development created a conceptual model (the Kelley model) for developing community-based palliative care programs that are customized to the needs of unique populations and geographies. She was the Lakehead University research chair in palliative care from 2012-2014. Since her retirement June 30, 2015, she has maintained her involvement in numerous national research initiatives. Currently she is a member of the Ontario Palliative Care Coalition and the Partnership Advisory Committee of the Ontario Palliative Care Network that is under development. Nationally, Dr. Kelley is Chair of the national LEAP Advisory Committee for Pallium Canada, providing leadership in the development of palliative care curriculum for health care professionals. Dr. Kelley was the recipient of the Canadian Hospice Palliative Care Association's 2011 Award of Excellence and the Queens Diamond Jubilee medal in 2012 in recognition of her contribution to Canadian palliative care practice, education and research.

Mr. Paul Labbe

Paul Labbe, BSc, BCL, ISMP, is a PalliumCanada board member. He is Executive Director of the Foundation for Sustainable Growth, a non-profit organization helping emerging countries achieve sustainable levels of economic growth. He spent most of his career in the field of international trade and finance. Starting as a Trade Officer at the Canadian Embassy in Paris, then returning to Canada as Chief of Staff to the Minister of Industry, Trade and Commerce. Between 1997 and 2000 Mr. Labbe was CEO and Chairman of Citibank Canada and prior to that, President and CEO of the Export Development Corporation, Canada's official export credit agency. He is formerly Director of Dundee Wealth Bank, and of SRTelecom Inc., (SRT), as well as Chairman of the Board of Comunicación y Telefonía Rural S.A. (CTR), SRT's wholly owned fixed wireless telecommunications company in Chile. Mr. Labbe serves on the Schulich School of Business' International MBA Advisory Board, and is President and Director of the Rideau Club of Ottawa and served for six years as a Governor of the Canadian Comprehensive Auditing Foundation.

Dr. Denise Marshall

Denise Marshall, BSc, MD, CCFP, FCFP, ABHMP(cert) has been a McMaster Family Medicine trained Palliative Care physician since 1989. After completing her residency and training in Family Medicine and Palliative Medicine, Dr. Marshall served as a Palliative Care physician at Hamilton Health Sciences, and then Director of the Palliative Care program at St. Joseph's Hospital, Hamilton. In 1997, she created a community-based Palliative Care Team in the west end of Niagara where she currently works. She has held several positions at McMaster including inaugural Director of the Division of Palliative Care, and Assistant Dean, Faculty of Health Sciences. She is also an academic physician at McMaster University, having a number of roles, including Undergraduate Director, Family Medicine (1999-2004). She was the inaugural Director of the Division of Palliative Care, Faculty of Health Sciences, which she created in 2003 and held until 2008. She teaches extensively at the undergraduate, postgraduate and practicing clinician levels. She has a scholarly interest in aspects of human suffering. She is now full-time Associate Professor at McMaster University and was appointed as Assistant Dean for Faculty Development, Faculty of Health Sciences in September 2006. She is founder of McNally House Hospice, in the Niagara region of Ontario, where much of her clinical work has been located for the past 17 years. After returning from sabbatical in 2014, where she explored Palliative Care as Public Health, she has assumed new provincial and national leadership roles in Palliative Care. Most recently, she has joined Pallium Canada, with funding from Health Canada, to forward a national agenda around Palliative Care as Public Health with particular emphasis on the Compassionate Communities model.

Dr. James Nininger

James R. Nininger, B.Com., MBA, PhD, was President and CEO of the Conference Board of Canada from 1978 to 2001. Prior to joining the Conference Board, Dr. Nininger was on the School of Business at Queen's University and prior to that had taught at the Ivey School of Business at the University of Western Ontario. He served on the board of directors of Canadian Pacific Railway Co., Power Corporation of Canada and the Canada Revenue Agency. He also served on the boards of a number of organizations in the not-for-profit sector including The Ottawa Hospital, the Canadian Patient Safety Institute, and the Community Foundations of Canada. He served as Chair of the Board of the Community Foundation of Ottawa. In all his activities he has taken a keen interest in governance. He was awarded an Honorary Doctorate from the University of Ottawa and the Honorary Associate Award of the Conference Board of Canada.

Rev. Dr. David Pfrimmer

David Pfrimmer, BA, MA, MA, D.Min. has served for ten years as the Principal-Dean and Professor of Public Ethics until September 2015. He is currently Professor of Public Ethics. He is an ordained Pastor in the Evangelical Lutheran Church in Canada (ELCIC). David was the Executive Secretary for the denomination and for twenty-five years served as Director of the Lutheran Office for Public Policy. He has represented the ELCIC on a wide range of ecumenical and multi-faith coalitions that have addressed issues of economic globalization, social and health policy, peace and disarmament, human rights and aboriginal rights. David served on the Ontario Multi-faith Council the developed policies and programs for chaplains in provincial institutions. He teaches in the area of public ethics at Waterloo Lutheran Seminary on the campus of Wilfrid Laurier University in Waterloo, Ontario.

Mr. Gérald Savoie

Gérald Savoie, BSC, MHA, CHE is a Pallium Canada Board member. Prior to joining Pallium he was President and CEO of Hôpital Montfort, Assistant Executive Director at Queensway-Carleton Hospital, Director of Planning and Coordination for the Conseil Régional de la santé et des services sociaux de l'Outaouais and Assistant Administrator at Hotel Dieu Hospital in Campbellton, New Brunswick. He also taught in the MHA program at the University of Ottawa. He has participated and led several collaborative and shared services initiatives in Quebec and Ontario, operational and provincial reviews in Ontario and New Brunswick, and resource allocation processes in Quebec and New Brunswick. Mr. Savoie has played significant leadership roles in major restructuring and transformation of the healthcare system at the local, regional, provincial and national levels. Mr. Savoie has received the Robert Wood Johnson Award, the Trudeau Medal and an Honorary Doctorate from the University of Ottawa.

Dr. Peter Tanuseputro

Peter Tanuseputro, MHSc, MD, CCFP, FRCPC, completed training as a Public Health and Preventive Medicine physician, and as a Family Physician at the University of Toronto. Peter is currently an Investigator at the Bruyère Research Institute, the Institute for Clinical Evaluative Sciences, and the Ottawa Hospital Research Institute, under the supervision of Dr. Doug Manuel. He also practices Family Medicine in the community. His research experience includes the development and application of tools to measure the health of populations and the burden of behavioural risk factors. His current research includes using linked health administrative databases to develop population perspectives on health care use and cost associated with aging and end of life in Ontario.

Mr. Gord Tulloch

Gord Tulloch, BAHons, MA, is the Director of Innovation at posAbilities, a non-profit, BC charity that provides a broad spectrum of service to persons with disabilities and their families. In the past several years he has focused on the development of networks, services, initiatives, and prototypes that involve community participation and that engender more socially resilient lives, neighbourhoods and communities. This work also includes the exploration and testing of new roles within the public and private sector.