

DIALOGUES ON ABORIGINAL-FOCUSED HOSPICE
PALLIATIVE CARE IN RURAL AND REMOTE BRITISH
COLUMBIA, CANADA



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ABOUT THE COVER ARTWORK:

Artist's Biography:

Maynard Johnny Jr. was born April 4, 1973 in Campbell River, British Columbia. He is of Coast Salish and Kwakwaka'wakw descent. Maynard began drawing at the age of six and designing Native Art by the age of seventeen. He has created logos for a number of businesses and First Nation organizations. Maynard has participated in many gallery and museum shows, and has been published in catalogues and books about Native Art over the years. He has focused mostly on graphic design, but is working towards including new mediums such as wood and precious metals. Maynard hopes to create Art for all to enjoy.



Story of "Owl":

The Owl in Coast Salish culture is affiliated with death. One story tells of the Owl being a guide to the Spirit World. It is believed that because the Owl can see so well in the dark, when one passes on the Owl guides their soul through the darkness of death to the Ancestors that passed before them, to the Spirit World.

I designed the Owl with a human face in the tail as if the Owl is carrying the human through to the Spirit World and the legs and talons of the Owl are the human's arms and hands in an upward position, which is a gesture we use in Salish Culture to show thanks and appreciation.

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INTRODUCTION

Hospice palliative care is a relatively new field of health and social service provision; Aboriginal-focused hospice palliative care is an even more recent development. As such, there are significant gaps in research and knowledge, both of which need to be filled so as to inform policy development as well as program and service delivery and design. Consequently, a standard for Aboriginal hospice palliative care has yet to materialize in Canada. In response, Health Canada funded the Canadian Hospice Palliative Care Association (CHCPA) in 2007 to produce a gaps analysis concerning Aboriginal palliative care. The findings of this analysis offer a rich information source for assisting with refining the vision for Aboriginal-focused hospice palliative care in Canada. This gaps analysis has also served as a point of departure to begin a dialogue at the national level. More information is, however, required in order to fully determine needs and priorities. This includes dialoguing about Aboriginal-focused hospice palliative care at the local-regional level.

Three face-to-face dialogues were held across rural and remote areas of British Columbia (BC), in Castlegar, Prince George, and We Wai Kai Nation/Campbell River specifically, in order to address the knowledge gap identified above regarding the need to assess local-regional level priorities (see Figure 1). The primary goal of these dialogues was to facilitate establishing research and practice priorities for Aboriginal-focused hospice palliative care in BC through creating the opportunity to form relationships and collaborations across academic, governmental, health service, and community stakeholders. The long-term objective of these dialogues is to develop and rationalize an innovative ‘Made for BC’ Aboriginal-focused hospice palliative care research and service delivery agenda that is responsive to the needs of Aboriginal peoples in the three distinct rural and remote regions of focus. The following report synthesises each of the three dialogues, presents stakeholder-identified priorities, and concludes with an identification of post-dialogue next steps.



Figure 1: Dialogue Locations in BC

BACKGROUND & RELEVANCE

Access to hospice palliative care services is often limited in rural and remote communities. For Aboriginal peoples living in BC, rurality and a lack of cultural sensitivity can create barriers to accessing and receiving quality palliative care. In 2008, a study focused on palliative care in the BC interior demonstrated that issues of cultural visibility, contradictions in the provision of palliative care and a lack of culturally sensitive training creates additional obstacles for Aboriginal people in terms of accessing formalized palliative care. As hospice palliative care is a type of health service often neglected by decision-makers, the issue of lack of attention to cultural sensitivity training has yet to be properly considered in policy-setting agendas. It is for these reasons that we held the dialogues introduced in the last section. The need to dialogue about Aboriginal-focused hospice palliative care has been observed by others. The CHPCA, for example, contends that in order to understand how to advance the delivery of hospice palliative care for Aboriginal peoples in Canada, we need to bring together First Nations, Inuit, and Métis knowledge with mainstream scientific or empirical knowledge. Thus, holding dialogues focused on this issue responds not only to knowledge gaps but also to the call to engage Aboriginal peoples in hospice palliative care priority setting in a meaningful way that respects their knowledge and introduces it to those who operate within a more scientific or empirical paradigm.

Aboriginal peoples in Canada represent many distinct cultures. Approximately 170,000 Aboriginal peoples live in BC alone, with over 200 separate First Nations and a strong Métis presence throughout the province. Yet they share a common history through the colonial experience of marginalization, exploitation, and maltreatment. Shortly after contact with white settlers and up to the present, Aboriginal peoples have also shared significant health inequalities relative to the non-Aboriginal Canadian population.

The policies and procedures stemming from the Indian Act of 1876 have attempted to define how Aboriginal peoples in Canada encounter life *and* death. Although Aboriginal peoples across Canada are now beginning to live longer (but still with shorter life expectancies than their non-Aboriginal counterparts), they are beginning to see an increase in chronic and degenerative disease such as diabetes, cancer, and heart disease and their related impairments, which were not historically found in their societies. Longevity and chronic illness tend to lead to a protracted end-of-life stage, thus requiring concentrated hospice palliative support. However, such support is generally not accessible in their home communities and often requires transportation out to an institutionalized setting such as a hospital. While Aboriginal peoples access the same hospice palliative care services as other Canadians, these services are not typically designed to accommodate cultural differences or create an atmosphere of cultural safety.

Hospice palliative care services in the province of BC are not evenly distributed; typically team-based and specialized care is found only in larger urban centres. Family physicians in rural areas tend to take up the slack by providing non-specialized palliative care. The BC Ministry of Health acknowledges that current access to hospice palliative care is inadequate for many residents in the province and that the regionalized health care

system must address this issue. In 2006 the BC Ministry of Health released a framework for hospice palliative care. In it, administration, accessibility, and coordination are prioritized but the specific needs of non-urban communities are not addressed and only cursory acknowledgement is made with respect to the need to offer culturally sensitive care to all citizens. Granted the framework is a point of departure, and not a strategy for how care should be provided; however, the lack of attention to cultural sensitivity at this early stage may prevent the prioritization of cultural sensitivity and safety. Numerous studies echo these issues, pointing out the barriers that hospice palliative care administrators and providers face regarding hospice palliative care prioritization and culturally sensitive care provision for Aboriginal peoples and the wide range of cultural, linguistic, and ethnic groups in Canada. As such, research is needed to: (1) document further challenges; and (2) identify strategies to move forward regarding the delivery of culturally sensitive and safe hospice palliative care for, by, and with Aboriginal peoples in Canada.

DIALOGUES ON ABORIGINAL-FOCUSED HOSPICE PALLIATIVE CARE: PLANNING OVERVIEW

The arrangements made to host the dialogues were different in each of the three BC regions visited. Through a partnership established with the Inter Tribal Health Authority and working relationships previously established by the academic hosts, invitations were sent to community members, health professionals, and health educators who were recognized as having expressed an interest in Aboriginal-focused hospice palliative care. Additional participants suggested by invitees were also contacted. Dialogue locations were chosen through a search of services that catered to the needs of local Aboriginal populations. This resulted in the Castlegar meeting being held at the Mir Centre for Peace on the grounds of Selkirk College, the Prince George meeting being held at the Prince George Nechako Aboriginal Education and Training Association (PGNAETA), and the We Wai Kai Nation/Campbell River meeting taking place at the Quinsam Health and Community Centre. We also extended invitations to participate in the dialogues to those people affiliated with these organizations.

The organization of the three dialogues remained constant. Each was structured as an open, participatory dialogue and divided into a morning and an afternoon session (see Appendix 1). The morning session was focused on participants sharing stories related to their experiences and knowledge of hospice palliative care. The afternoon session focused on generating a list of Aboriginal-focused palliative care issues in accordance to the needs and experiences of local participants. A number of questions were available to further stimulate brainstorming (see Appendix 2), though they were never relied on to generate discussion. These issues were then prioritized and further targeted discussion ensued. Each meeting closed with the participants generating a list of key stakeholders with whom to share this final report and to engage in future dialogue and research (see Appendix 3). The remaining sections of this report are dedicated to summarizing the three dialogues.

DIALOGUES ON ABORIGINAL-FOCUSED HOSPICE PALLIATIVE CARE: SUMMARIES

Highlighting the importance of local experiences, this section is intended to provide an understanding of the local conditions of Aboriginal-focused hospice palliative care in the three distinct regions of focus.

Castlegar

The stories that emerged from participants included a number of overlapping themes. In particular, many of these themes relate to the lack of hospice palliative care services and a formal structure for Aboriginal peoples in the region. In Castlegar, as with many of the communities in the Kootenay-Boundary region, there is no Band Office or Native Friendship Centre. From participants' perspectives, this lack of a physical gathering place posed a problem in that there was no easily identifiable place for Aboriginal residents to turn to for information and resources concerning hospice palliative care services and other forms of health and social care. Participants suggested that Aboriginal people living in the area have been either disconnected from their cultural practices or are hesitant to share their identities with others. It was noted that when approaching end of life, many people wish to reconnect with their traditional culture. However, with culturally-relevant information and practices being difficult to access, this may seem impossible.

Participants identified the need to create a culturally *and* physically appropriate space for dying; one that would accommodate the presence of family and friends and allow for the reinstatement of traditional and cultural practices. Participants suggested that by developing a training program focused on the needs of Aboriginal clients, hospice palliative care services could become more accessible and culturally sensitive. Participants were also vocal about the need to provide respite for families and care workers. One participant's statement "people do not stop dying when you are on vacation," demonstrated the tendency for care workers to take on an overwhelming workload. Also discussed was the importance of educating children on life stages, including end of life. An often sensitive matter, participants suggested that education in schools and at home would allow for a better cultural understanding of the processes surrounding and involved in the dying process, which has the potential to translate into a more holistic understanding of grief, death and dying in adulthood.

Prince George

Aboriginal communities in northern BC are typically remote, and therefore limited in terms of access to a number of things including on-site service providers. Thus, the provision of comprehensive health services is difficult. Participants acknowledged that long distance travel prevents timely access to care. They described how family members typically take on the responsibility of caring for those requiring hospice palliative care because of the lack of close proximity to formal service provision. Because of this reality, they also expressed concern that without formal training, families can feel unprepared and often fear making mistakes. Participants noted that lack of attention by community

health offices to family caregiving issues furthered feelings of isolation as their lack of engagement suggests that the needs of the family are not important. However, participants also recognized that communities do have strong potential for capacity building around providing hospice palliative care, especially if there were opportunities for formal training in informal caregiving at end of life. They agreed that utilizing the capacity present within the community would mean that care recipients would be able to access services locally and community members would receive training that would be directly beneficial to the community.

As many people approaching end of life do not wish to be institutionalized and would prefer to stay at home or in their home communities through the dying process, participants agreed that individuals should have choices about care location and with respect to whom they wished to be present. Participants also commented that making hospice palliative care services, and particularly equipment, available within communities and informing people of how to gain access to necessary services would further their abilities to have choices. Providing choice in its broadest sense was also understood to be important as it can allow for each case to be dealt with in the manner most suited to the individual. They noted that when individuals are relocated to sites away from their home communities, family members are often not able to visit their dying loved ones. As stated by one participant, a person may “die of loneliness because nobody [will be able to] visit [them].” As discussed at the Castlegar meeting, the importance of providing options for respite for caregivers and family members and educating children on grief, death and dying were identified as important at the community and family level.

We Wai Kai Nation / Campbell River

One of the central issues raised in the We Wai Kai/Campbell River dialogue was the importance of recognizing that every death is unique. Participants commented on the need to maintain dignity throughout the dying process for each care recipient and his/her family. To do this, the recognition of individual desires should be addressed and upheld throughout the dying process. However, as “everything can be a challenge in rural and remote communities,” participants recognized that the ability to provide choice in meeting individual needs was sometimes very difficult to achieve. Participants suggested that providing communities with equipment and basic training – and, perhaps most importantly, information about how to acquire them – would remove barriers in terms of providing timely access to hospice palliative care, and ultimately enhance the availability of choice. Training would also help familiarize community members with the dying process while allowing for on-site care.

It was apparent to many participants that an Aboriginal-focused hospice palliative care “toolkit” should be developed and available for people when they or a family member are dying. The toolkit would include different items as deemed appropriate by each community as well as checklists and resource information with the goal to prepare individuals and their families for the kinds of choices that may be encountered through the dying process. Further to the toolkit discussion, two tangible items were suggested

with sincere consideration. First, an Elder shared that she had put thought into her own eventual death and was seeking ways to ensure that her children would be left with minimal burden in terms of what had to be done under those circumstances, as well as her wishes for end of life care. Second, participants were interested in accessing and understanding current hospice palliative care options, especially when dealing with terminal illnesses. As in the previous two meetings, participants also identified the need of respite for family and caregivers.

ABORIGINAL-FOCUSED HOSPICE PALLIATIVE CARE: REGIONAL PRIORITIES

To generate a list of regional priorities for Aboriginal-focused hospice palliative care, participants were given an opportunity to brainstorm about issues based on the stories and experiences they had shared during the dialogues. Once the brainstorming session was exhausted, participants were asked to prioritize issues they deemed were the most pressing for their region. Presented here are the participants' top three ranked priorities, by region.

Castlegar

As stated in the previous section, the lack of a cultural centre or organizing body within the Kootenay region creates additional difficulties for Aboriginal peoples wishing to access culturally safe hospice palliative care. Because of this, the **number one** regional priority is the need to develop sensitivity and respect for individuals, in both body and spirit, and in doing so providing the option to die in a familiar place with familiar people, other loved ones, and culturally significant items (e.g., medicines, ceremonies, objects). This also includes the option for family and pets to remain with an individual in a formal care setting. The **number two** regional priority is to determine whether the hospice palliative care needs of the family and individual are currently being met and, if not, to identify how these needs can be met. Families must have access to information about services and be informed of their options so that they can access care that most adequately suits the needs of the dying person. The **number three** priority is to enhance the accessibility of resources and information, particularly so as to enable access to and choice about services.

In response to these three identified issues and at the request of the Aboriginal Health Program Advisor and Patient Navigator for the Kootenay-Boundary Health Service Area present at the dialogue, the team immediately created a series of PowerPoint slides intended to be used to inform community members about existing hospice palliative care resources in their area. This Aboriginal Health Program Advisor also intends to use the slides in presentations given to health officials to inform them of the current state of Aboriginal-focused hospice palliative care in the region.

Prince George

Having centred their dialogue around the ability to have choice, the **number one** priority issue for Aboriginal-focused hospice palliative care in northern BC shared by the Prince George participants is the need to support those wishing to die at home. Providing training and access to equipment would allow for greater choice in the location of dying, while keeping the resources and services necessary for on-site care in the community could better support and enable home deaths. The **number two** regional priority issue is the importance of addressing the need to provide respite and counselling for caregivers and family members. As community members and care workers are often overburdened with providing care, the provision of respite not only allows caregivers to experience a moment of relief or to take time for grieving, but also ensures that the quality of care is maintained. The **number three** priority is directly related to achieving the first two priorities: creating training opportunities for community caregivers. By providing willing community members with counselling and hospice palliative care training choice is maintained and, if desired, care could be accessed locally.

During this dialogue participants were eager to create networks between the health care and voluntary sector providers present and community members. At the meeting, news of an upcoming local training seminar offered by the BC Hospice Palliative Care Association (BHPCA) was announced. Four Aboriginal community members expressed interest in attending, and so the team and the BHPCA jointly contributed funds to assist with covering the costs for them to attend. In doing so, these participants were able to bring valuable skills back to their communities.

We Wai Kai Nation / Campbell River

Participants at the We Wai Kai Nation/Campbell River meeting discussed the importance of identifying and utilizing the capacity already existing within communities to enhance the provision of Aboriginal-focused hospice palliative care. However, as every community is different, the **number one** priority is to determine the educational needs of each community, and particularly those relating to hospice palliative care. Through this, capacity can be built and community members would be able to provide on-site care for one another. The other two priorities are interrelated in terms of discussions surrounding remote and rural communities. The **number two** priority issue is to address the challenge of accessing resources, while the **number three** priority issue is to address the challenge of accessing supplies throughout the large number of rural and remote communities in BC. Variations in seasonal conditions and the high cost of equipment often prevent communities from having timely access to supplies and resources required to provide an adequate level of care.

During the dialogue it was suggested that the creation of an equipment-exchange network could assist with connecting people in need of supplies to those who have them, thus more easily and quickly distributing needed equipment. For example, a participant shared important and much needed information regarding extra hospital beds that could be distributed to local Aboriginal communities. An extended dialogue surrounding the

availability of equipment in the Vancouver Island region concluded with the suggestion of creating an online equipment-exchange network. There was a desire among participants to work together to figure out ways to create such a network. Participants from a number of different organizations and agencies expressed the desire to remain in contact and continue to work together on this idea. A contact list was distributed to all those who attended to facilitate this process. Discussions surrounding the creation of an online network for trading and distributing of palliative care supplies remain ongoing.

SYNTHESIS: WHERE DO WE GO FROM HERE?

Conversations during the three dialogues highlighted the importance of regional differences in the current state of Aboriginal-focused hospice palliative care and the identification of priorities. Just as each death is unique, regional-specific barriers and facilitators play a significant role in shaping whether or not Aboriginal people die a ‘good death,’ while maintaining cultural and traditional values. Aboriginal people living in rural and remote communities may have a strong desire to provide formal and informal local hospice palliative care. However, accessing the necessary human and material resources, such as training and supplies, and upholding the need for choice often make this goal difficult to achieve. Through establishing and maintaining a working relationship with a variety of community members, health officials, and health workers interested in hospice palliative care it is hoped that research can be conducted that utilizes these networks with the goal of working towards the creation of a ‘Made for BC’ set of guidelines for Aboriginal-focused hospice palliative care. To do this it is necessary to work with regional stakeholders and communities. By doing so, inequities in the provision of services and a heightened level of cultural sensitivity can be addressed so as to uphold the integrity of Aboriginal peoples during the end of life stage.

ACKNOWLEDGEMENTS

We would especially like to thank all of those who attended and contributed to the dialogues (see Appendix 4). We also extend deep thanks to Johnny Maynard Jr. for providing the cover artwork. We acknowledge, with great appreciation, the Canadian Institutes of Health Research - Institute for Aboriginal Peoples’ Health for providing funding for these dialogues. We also acknowledge the BC Rural & Remote Health Research Network (BCRRHRN) for providing us with notepads and pens that were used during the dialogues. We would also like to thank and acknowledge the organizations that hosted the meetings: Selkirk College Castlegar Campus (Sinixt Territory), the Prince George Nechako Aboriginal Education and Training Association (Lheidli T’enneh Territory) and the Quinsam Health Centre (We Wai Kai territory).

APPENDIX 1: MEETING AGENDA FOR DIALOGUES

Planning for Aboriginal-Focused Hospice Palliative Care in Rural and Remote British Columbia

The goal of this multi-stakeholder meeting on Aboriginal-focused hospice palliative care in rural and remote BC is to facilitate research priority-setting through identifying existing strengths, limitations, and challenges. The long term objective of our team is to develop – and rationalize – a ‘Made for BC’ Aboriginal-focused hospice palliative care research agenda that is responsive to the needs of those living in rural and remote areas that can ultimately inform on-the-ground practice and administration. Today’s dialogue provides an opportunity to coalesce a collaborative process of decision-making regarding setting this research agenda. We are grateful to the Canadian Institutes of Health Research for funding a series of three such consultative meetings over the coming weeks.

9:30 - 10:00	Welcome, Introductions, and Orientation
10:00 - 10:30	A brief overview of our ongoing research and the impetus for today’s meeting
10:30 - 10:45	Break
10:45 - 11:30	Open sharing of stories and experiences that relate to today’s focus
11:30 - 12:00	A summary and discussion of key challenges regarding rural and remote palliative care and Aboriginal-focused hospice palliative care identified in the international literature
12:00 - 12:30	Lunch break
12:30 - 2:00	Brainstorming discussion
2:00 - 2:15	Break
2:15 - 3:00	Brainstorming synthesis
3:00 - 3:30	Summary and next steps

APPENDIX 2: BRAINSTORMING QUESTIONS

- How do you describe a ‘good’ death?
- What are some of the themes and beliefs that come from your Nation’s teachings about death and dying? Do you know of any main differences in these teachings between different Nations in the region? If so, what are they?
- What are some strengths or good points about how hospice palliative care is offered in BC generally, or your region specifically, at the moment? What about to Aboriginal people specifically?
- What are some of the challenges associated with offering hospice palliative care in your region? What about to Aboriginal people specifically?
- If there was one thing that you could change about the current provision of hospice palliative care to Aboriginal people in your region, what would that be?
- What are the main priorities when it comes to enhancing Aboriginal health services in BC? How important is enhancing hospice palliative care relative to these other priorities?
- What’s your vision for Aboriginal-focused hospice palliative care in your region? What about throughout the province? What changes would you make? What things would remain the same? What considerations are specific to location (e.g., rural and remote communities in particular)? What considerations are specific to Aboriginal people and cultures?
- In what ways should the diversity between different First Nations and also between different Aboriginal groups (i.e., First Nations, Inuit, Métis) be considered in hospice palliative care service planning and development? What are some important considerations in this regard?
- Who are the stakeholders involved in Aboriginal-focused hospice palliative care in BC? What roles do they play? Are any people or groups not effectively engaged?
- What has led to your new/long-standing interest in/passionate about Aboriginal-focused hospice palliative care?
- What’s unique about caring for dying individuals that makes it different from other forms of care? What are some of its specific needs?
- Why might things such as culture, ethnicity and language be important considerations in hospice palliative care in general in BC? And what about in your region?
- What are some of the things you worry/think about in terms of your aging family members and friends in the region?

APPENDIX 3: PARTICIPANT-GENERATED LIST OF STAKEHOLDERS

1. BC Hospice Palliative Care Association
2. Canadian Hospice Palliative Care Association
3. Indian and Northern Affairs Canada
4. Provincial Health Authorities
5. Inter Tribal Health Authority
6. BC First Nations Health Council
7. BC Rural and Remote Health Research Network
8. Network for Environments on Aboriginal Research BC
9. National Aboriginal Health Organization
10. BC Aboriginal Network on Disability Society
11. First Nations and Inuit Health Branch
12. Assembly of First Nations
13. Canadian Institutes of Health Research: Institute for Aboriginal Peoples' Health
14. Métis Nation BC
15. Members of the Legislative Assembly (and the general voting public)
16. First Nations Chiefs and Councils in BC
17. BC Ambulance service
18. Educational institutions
19. Canadian End-of-Life Coalition
20. University of Northern British Columbia Northern Medical Program
21. Canadian Virtual Hospice
22. Elders and families providing palliative care
23. BC Physicians Association
24. Hospice societies
25. End of Life Researchers
26. BC Ministry of Health
27. Health Committee Directors
28. Non-Insured Health Benefits (Health Canada)
29. College of Registered Nurses of BC
30. Associations with similar mandates such as the Canadian Cancer Society, Canadian Diabetes, and the Heart and Stroke Foundations.

APPENDIX 4: PARTICIPANTS

Castlegar

Christine Knippelberg (Health Worker, Lower Columbia First Nation), Lisa Slood (Health Worker, Lower Columbia First Nation), Lucie Poisson (Kootenay-Boundary Aboriginal Liaison Officer, Interior Health Authority), Joan Holmes (Coordinator, Kaslo Hospice), Callie Troubridge (Coordinator, Trail Hospice Palliative Care Program), Suzanne Lehbauer (Director, Castlegar Hospice Society), Tammy McCluskey (Instructor, Selkirk College), Duncan Grady (Healer and Teacher), Valorie Crooks (Researcher, Simon Fraser University), Heather Castleden (Researcher, Dalhousie University), Vanessa Sloan Morgan (Meeting Coordinator, University of Victoria)

Prince George

Aileen Prince (Community Health Worker, Nak'azdli), Frieda Prince (Community Member, Nak'azdli), Hazel Burt (Formal Care Provider), Celena Jack (Elder), Doreen Isadore (Community Member, Bear Lake), Gary M Williams (Community Member, Gitwangakr), Neil Hanlon (Researcher, University of Northern British Columbia), Armand Sam (Community Member, Nak'azdli), Joe Joseph Houston (Community Member), J. Dennis Hausselman (Métis Community Member, Prince George), Ed Dennis (Community Member), Susan Graf (Palliative Care Nurse, Quesnel), Carol Weremy (Northern Representative, BC Hospice Palliative Care Association), Donalda Carson (Executive Director, Prince George Hospice Society), Frank Frederick Sr. (Lheidli T'enneh Elder), Eleanor Skin (Elder), Robert Frederick (Community Member, Prince George), Heather Castleden (Researcher, Dalhousie University), Valorie Crooks (Researcher, Simon Fraser University), Vanessa Sloan Morgan (Meeting Coordinator, University of Victoria)

We Wai Kai Nation / Campbell River

Sally Williams (Health Consultant/Advocate); Michael Downing (Research Director & Palliative Care Physician, Victoria Hospice); Eliette Harry (Community Health Representative, Homalco); Jonathan Chickite (Community Care Support Worker, Homalco); Lynn Turner (Ed & Ty Watson House Manager, Alberni Valley Hospice); Joy Phillips (Community Health Nurse); Terri Odeneal (Director, Comox Valley Hospice Society); Nadine Schuurman (Researcher, Simon Fraser University); Heather Tufts (Community Activist/Retired Teacher); Heather Castleden (Researcher, Dalhousie University); Cindy Inrig (Councillor); Angelika Starr (Health Director/Social Worker); Janice Knighton (Inter Tribal Health Authority, Nanaimo); Lara Serika (KDC Health Float Nurse); Michelle Ham (KDC/Quinsam/ITHA/Homalco Community Health Representative/RN); Valorie Crooks (Researcher, Simon Fraser University); Melissa Giesbrecht (Graduate Student, Simon Fraser University); Vanessa Sloan Morgan (Meeting Coordinator, University of Victoria)