



**Taking Stock: Determining Palliative Education Needs in Canada**  
**An Initiative of the Quality End-of-Life Care Coalition of Canada's Education  
Committee**  
A Summary/Evaluation Report



## **Table of Contents**

<b>Background</b> .....	3
<b>Survey objectives</b> .....	3
<b>Survey approach and methodology</b> .....	3
<b>Survey results</b> .....	3
<b>Section I: Profile of survey respondents'</b> .....	4
<b>Section II: Education priorities, needs, and gaps, and barriers to meeting palliative care education needs</b> .....	7
<b>Section III: Current and preferred learning approaches</b> .....	11
<b>Recommendations to Sector</b> .....	14



## Background

The Quality End-of-Life Care Coalition of Canada (QELCCC) is a national membership organization comprised of over 35 stakeholders in the field of hospice palliative and end-of-life care. The QELCCC believes that all Canadians have the right to quality end-of-life care that allows them to die with dignity, free of pain, surrounded by their loved ones, and in a setting of their choice. For more information on the QELCCC, please visit their website [here](#) or at: <http://www.qelccc.ca>.

The Education Committee is one of the standing working groups of the QELCCC. Their mandate is to:

1. Promote palliative and end-of-life care education across the learning continuum from undergraduate to post graduate and continuous professional development;
2. Provide a forum to disseminate best practices across the learning continuum; and
3. Identify solutions to challenges.

## Survey objectives

In line with the Coalitions 'Blueprint for Action 2020-2025' and as part of the 2020 work plan, the QELCCC's Education Committee conducted a national survey to determine palliative care education and training needs in Canada. Specifically, this initiative was developed to identify:

1. Gaps, both current and future, where learners require more education, information, tools, and/or resources to provide better palliative care to their patients and their families; and
2. Existing barriers related to meeting personal or organizational palliative care education needs and preferred learning approaches.

For the purposes of the survey, the term "palliative care" refers to the needs of patients with serious illnesses. It includes palliative care delivered across the illness trajectory, from earlier in the illness to end of life, as well as grief and bereavement support.

## Survey approach and methodology

The survey was developed with input from the QELCCC Education and Executive committee and was comprised of 18 questions (See Annex 1 for English survey questions). It was housed online on Alchemer (formerly Survey Gizmo) and was available in both English and French. The survey was open from July 9 to September 18, 2020, and targeted a range of health care professionals, leaders, researchers, and those responsible for education, training, and development within their organization. Links to the English and French surveys were shared with various stakeholder groups across Canada, and with QELCCC members for distribution to target audiences. The survey was also promoted on various social media platforms (i.e., Twitter, LinkedIn, Instagram, Facebook). These channels were also used to send reminder messages. Descriptive statistics (i.e., frequencies, percentages) were calculated for quantitative data. Open-ended questions were analyzed inductively and deductively.

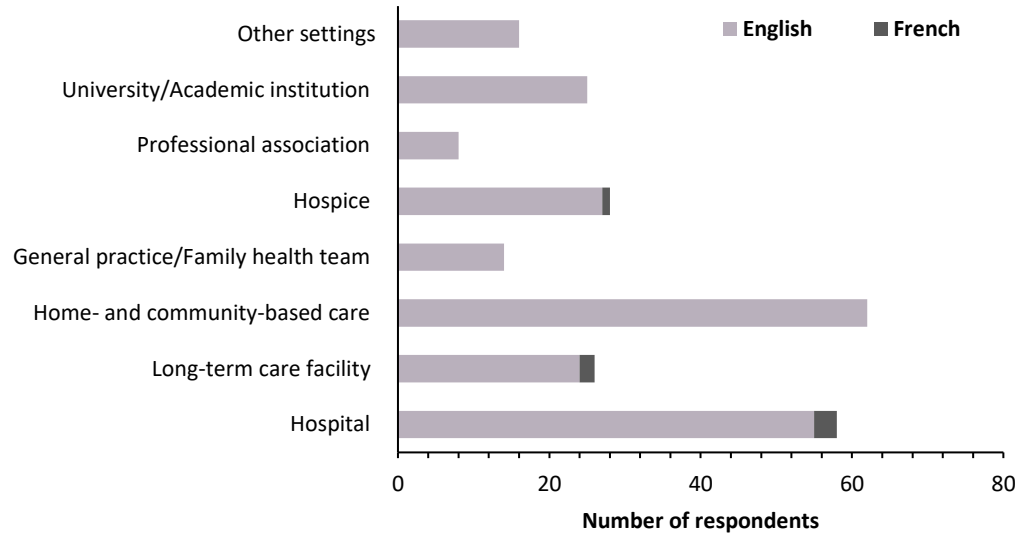
## Survey results

A total of 152 responses were recorded – 145 English and 7 French. After removing incomplete and partial responses, 127 responses were analyzed – 121 English and 6 French.

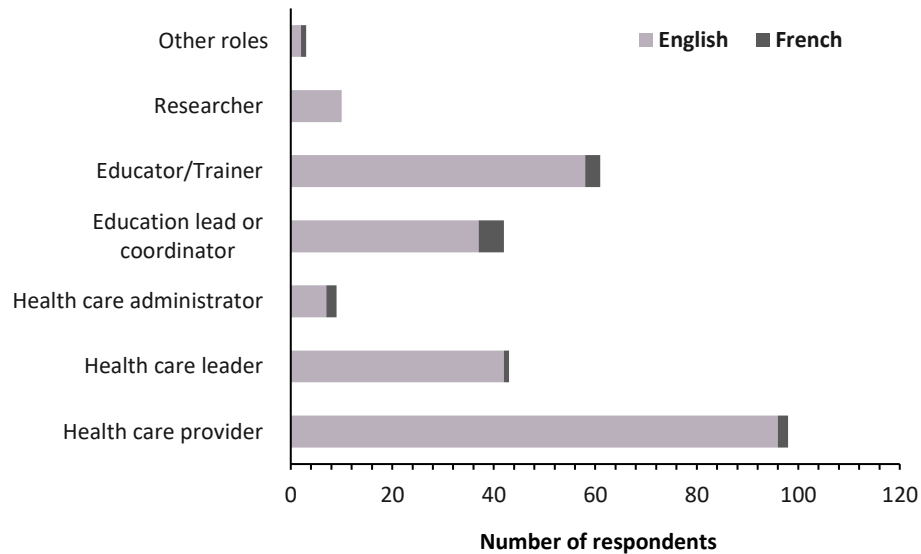
## Section I: Profile of survey respondents'

The following section outlines the profile of survey respondents. It includes information on respondent's work setting, work role, profession, educational role (if applicable) as well as the province or territory they work within and the number of years they have been working in health care.

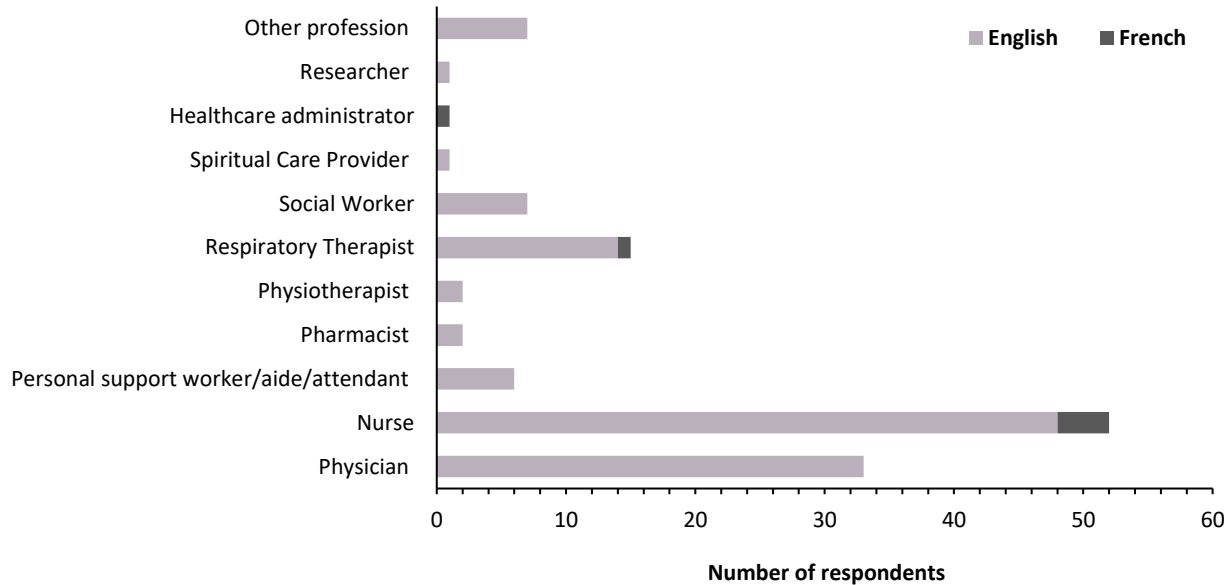
**Work setting(s):** Many respondents reported working in multiple settings. The most common were home- and community-based care settings (49%), hospitals (46%), hospice (22%), long-term care facilities (21%), and university/academic institutions (20%). "Other settings" included: cancer/palliative care clinic, dementia care facility, geriatric clinic, retirement/group home, health charity (non-profit organization), outpatient programs, and regional and provincial agencies.



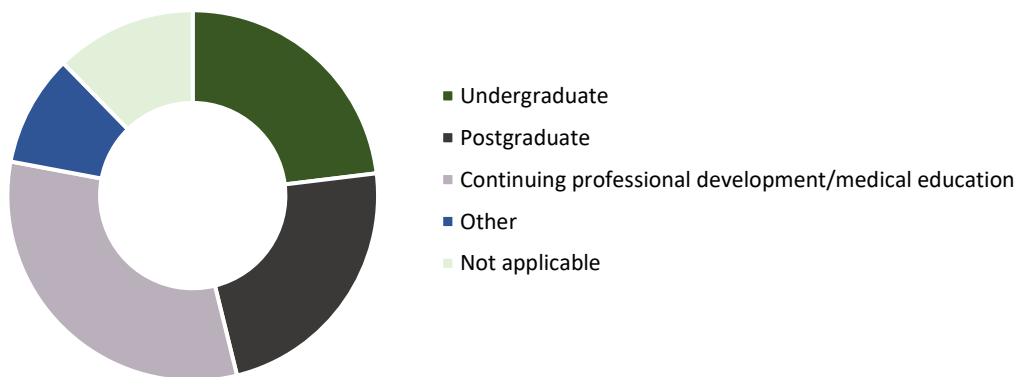
**Work role(s):** Many respondents reported multiple work roles, with the most common roles being health care providers (77%), educators/trainers (48%), health care leaders (34%), and education leads or coordinators (33%). A small percentage of respondents (<10%) reported working as a health care administrator or researcher.



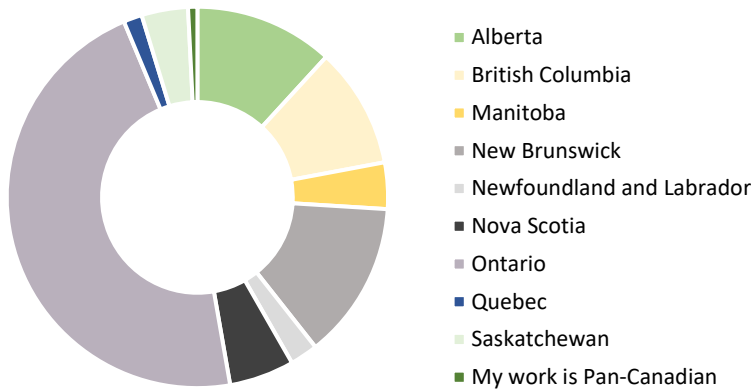
**Profession:** Most respondents were either nurses (41%), physicians (26%), or respiratory therapists (12%). A limited number of social workers (6%), personal support workers (5%), pharmacists (2%), physiotherapists (2%), spiritual care providers (1%), health care administrators (1%) and researchers (1%) participated. The sample did not include any paramedics, volunteers, family members, or caregivers. Other professions reported (6%) included nurse practitioners, a clinical nurse specialist, and certified respiratory educator.



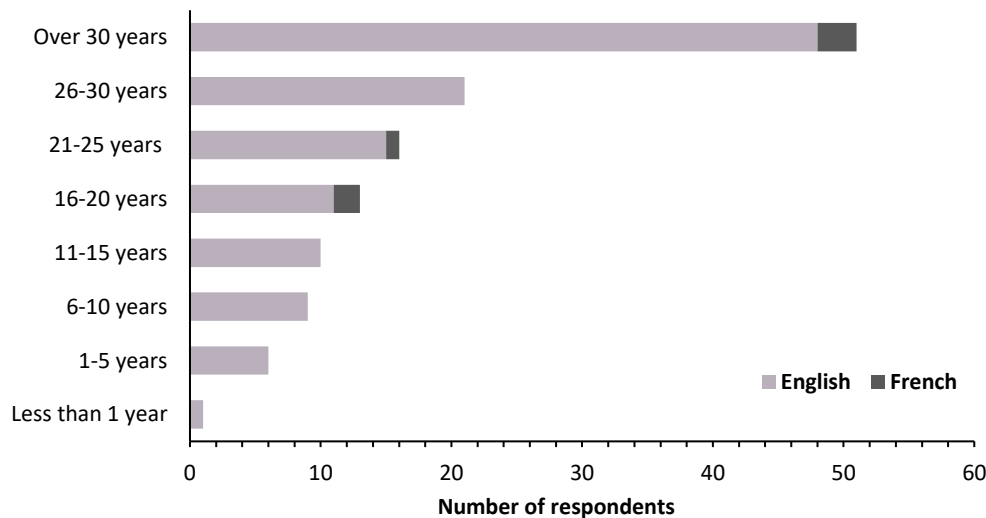
**Educational role:** One hundred and eight respondents (85%) indicated that they have an educational role in their work. Of these, 57% reported that their role pertains to the continuing professional development/medical education level, 42% to the undergraduate level, and 42% to the postgraduate level. “Other” educational roles included: educating staff, frontline workers, health care professionals, patients and their families, education in the community, as well as facilitating LEAP, diploma nursing courses, and Canadian Nurses Association (CNA) Certification.



**Province or territory:** Most respondents reported working in either Ontario (46%), New Brunswick (13%), Alberta (12%) or British Columbia (10%). The remaining provinces accounted for less than 20% of responses and none of the respondents reported working in the Yukon, Nunavut, or the Northwest Territories. All French respondents reported working in either New Brunswick (83.3%) or Quebec (16.7%).



**Years working in health care:** 80% of respondents reported working in health care for more than 15 years with 40% reporting over 30 years, 17% between 26-30 years, and 13% between 21-25 years. Under 10% of respondents reported working in health care for 5 years or less.



## **Section II: Education priorities, needs, and gaps, and barriers to meeting palliative care education needs**

The following section outlines respondents personal and/or organizational palliative care (PC) education priorities and needs, anticipated PC-related gaps for non-PC specialists, and an overview of the various barriers respondents and their organizations face when trying to meet PC education needs. This section corresponds to survey questions 7 through 10 (See Annex 1).

### **1. Education priorities: Key areas/themes and targeted learners**

**Areas/themes:** The most frequently reported education priorities, in terms of areas and themes, were related to symptom assessment and management, communication and having difficult conversations, and planning for and providing PC.

One fifth of respondents identified communication and having difficult conversations with patients and their families as a key education priority. Specific priorities included developing and applying communication skills (i.e., communicating effectively, truthfully, and empathetically), and how and when to have difficult/serious illness conversations. Having conversations around goals of care (GOC), disease progression, and death and dying with patients and their families were the most frequently reported priorities in this area.

A quarter of respondents identified symptom assessment and management as a key education priority in their context. Specific priorities included how to identify patients requiring PC and identifying them earlier on in the illness trajectory, recognizing and managing symptoms (e.g., pain, nausea, vomiting, dyspnea, delirium, frailty), recognizing signs of dying, and safely prescribing/deprescribing and administering medications (i.e., opioids, methadone) to ensure patients needs are met. Several respondents also noted COVID-19 symptom management as a priority in their setting.

Over 30% of respondents identified priorities related to planning for and providing PC. The main priorities noted by respondents were related to formulating GOC and advance care planning (ACP) for symptom changes and end of life, providing person and family-centered care including grief and bereavement support, and providing emotional, spiritual, and cultural care. Several respondents noted shared decision making and interdisciplinary approaches to care as key education priorities, and collaboration among sectors for continuity of care. Providing PC to patients outside of oncology and distinguishing and understanding the differences between PC and medical assistance in dying (MAID) were also noted by several respondents. Although less frequently reported, equity, inclusivity, and cultural safety/competency when providing PC as well as ethical and legal processes (e.g., wills, health care consent, process of assigning power of attorneys and health advocates) were identified as important education priorities.

**Targeted learners:** A wide range of targeted learners and priorities for training/education in PC were identified. Many respondents noted that all health care providers (HCP) should receive foundational education in PC and training in basic PC competencies. LEAP training for nurses and physicians, mandatory PC education and rotations for medical residents, and tailored education/training for different professionals (students, physicians, nurses, personal support workers, frontline staff) and

across different settings (e.g., long-term care, home care, hospice, hospital) were deemed to be important. One respondent noted: *“our team (palliative consultation service) identified that primary caregivers (health care assistants (HCA), licensed practical nurse (LPN), registered nurse (RN), allied health physicians) require education about palliative care with a focus on effective communication, having difficult conversations, understanding the difference between palliative care and MAID, providing holistic care, effective symptom management, and psychosocial support for the patient and family. We have separated our learners into groups so that the education can be targeted specifically. E.g. HCA palliative course, LPN/RN course, physician course.”*

A small number of respondents noted that they were unaware of any educational priorities in their setting or that there was no PC education and/or focus within their setting.

## **2. Palliative care education needs**

With respect to being able to provide PC to patients, the most significant education needs reported were related to pain and symptom management (e.g., prescribing/deprescribing and administering medications, opioid use, managing vomiting, nausea, dyspnea) – reported by 21% of respondents – and communication and having difficult conversations (i.e., how and when to have difficult/serious illness conversations) – reported by 9% of respondents. Though reported to a lesser extent (<5% of respondents), managing the needs of patients and their families, and providing grief and bereavement support were also noted as significant education needs related to providing PC to patients.

Many respondents reported there is a lack of basic understanding of PC (i.e., what it is and how it differs from an end of life (EOL) approach) and emphasized the need for all HCPs and professionals working in hospital and community settings to have foundational knowledge, skills, and confidence to support PC efforts. Respondents also emphasized the need for greater education and training opportunities and noted that time and costs associated with education and training, staff shortages and difficulties arranging backfill, and lack of managerial and funding support as significant barriers to accessing opportunities. Respondents reported a need for frequent and ongoing education and training opportunities (especially at low or no-cost), greater awareness of where to access resources (especially for evidence-based and best practices), and greater managerial support. For students, respondents suggested that more curriculum development and knowledge to practice opportunities are needed.

Several respondents also highlighted the need for a change in culture and a shift in the approach to PC that goes beyond the medical model and better addresses the diverse needs and experiences of people in Canada. One respondent noted: *“My organization believes the most significant need is to teach primary care providers to provide palliative care. In contrast, I believe the most pressing education need is understanding the patient and family experience of palliative care systems that only espouse one worldview of care provision, health and disease that is often based on the “Canadian” urban population and excludes the worldviews of patients and families from unique and distinct cultural and ethnic backgrounds or rural locations.”*



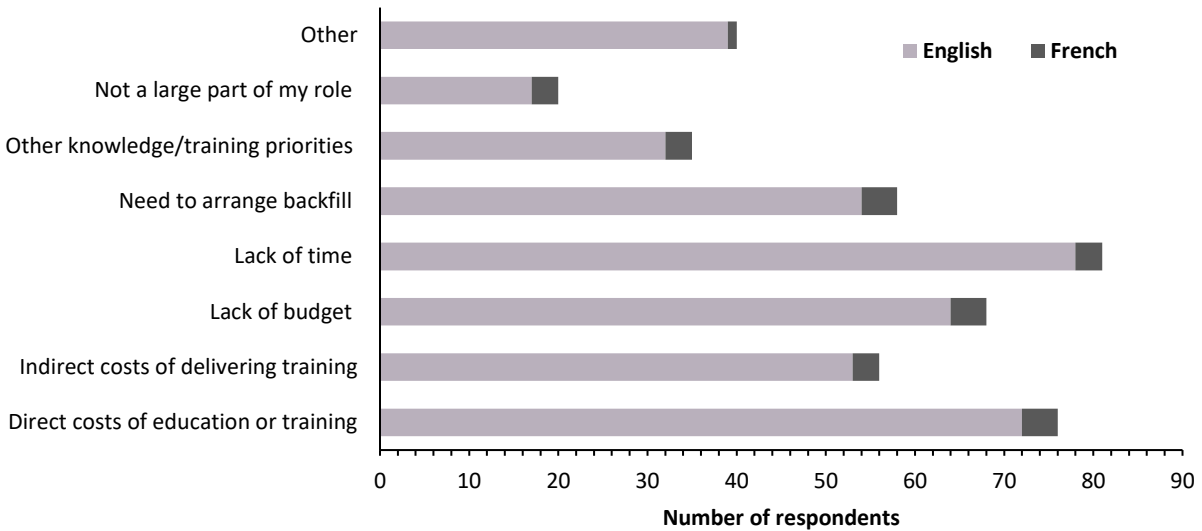
### **3. Palliative care-related gaps for primary and generalist-level health care workers**

Given the shortage of specialized PC physicians, nurses and staff, respondents reported a need for other non-PC specialists (e.g., primary and generalist-level health care workers) to help support and provide PC to patients across different settings. Respondents reported that non-PC specialists often lack foundational knowledge, basic competencies/skills, and confidence to provide quality PC to patients and their families. Specifically, they noted that non-PC specialists require more education to understand what PC is and why it is important, and further training to: identify patients who require PC and when to refer them (especially early on in the disease trajectory), manage symptoms (i.e., prescribing/deprescribing medications), assist with ACP, effectively communicate and have difficult conversations with patients and their families, and provide grief and bereavement support. A lack of organizational buy-in to PC approaches, scarcity of resources (i.e., time, funding, staff), and lack of support from managers/organizations were seen as the biggest barriers to educating and training non-PC specialists.

Respondents also emphasized the need to develop clear pathways and system structures so HCPs can work collaboratively within and across settings to provide PC to patients. Poor communication between HCPs, and the absence of reliable systems of PC make it difficult to provide care as part of an interdisciplinary team. Other PC-related gaps identified by respondents included the need to better understand MAID, PC provision in patients with non-cancer diseases, providing care and allowing patients to die at home, timely access to PC specialists and resources to guide patients and their families, and providing equitable and culturally safe and competent care. One respondent noted: *“We are still seeing a lack of advanced care planning, goals of care discussions, early introduction of palliative care for those with chronic diseases that are progressing in primary care. In addition, as cultural and ethnic considerations are left out of or poorly addressed in education for all health care providers in Canada this continues to contribute to poor experiences for patients and families with life limiting illness.”*

#### 4. Barriers to meeting palliative care education/training needs

Over half of respondents reported lack of time (64%), direct costs of education/training (60%), and lack of budget (54%) as getting in their way of meeting PC education needs. Other important barriers included indirect costs of delivering training (44%), needing to arrange backfill (46%), and other knowledge/training priorities (28%). Many respondents also noted COVID-19 and lack of organizational support, interest, and recognition of PC education needs as significant barriers to meeting PC education/training needs.



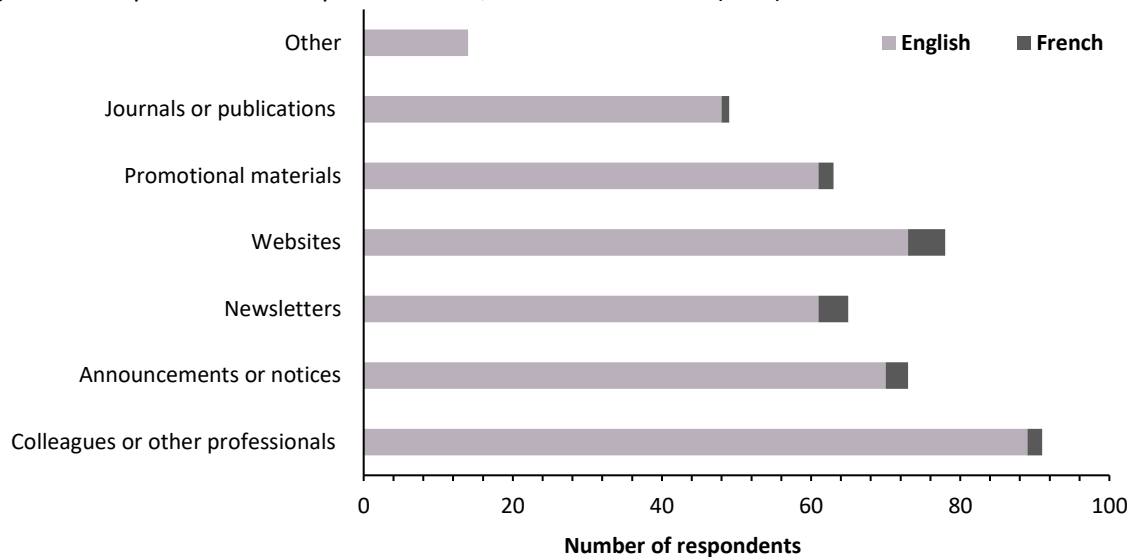
## Section III: Current and preferred learning approaches

### ***Current learning approaches***

The following section outlines current learning approaches and corresponds to survey questions 11 and 12 (See Annex 1). The section outlining current learning approaches includes information on where respondents and their organizations mainly receive information from about PC education resources, and how they prefer to learn/satisfy their education needs.

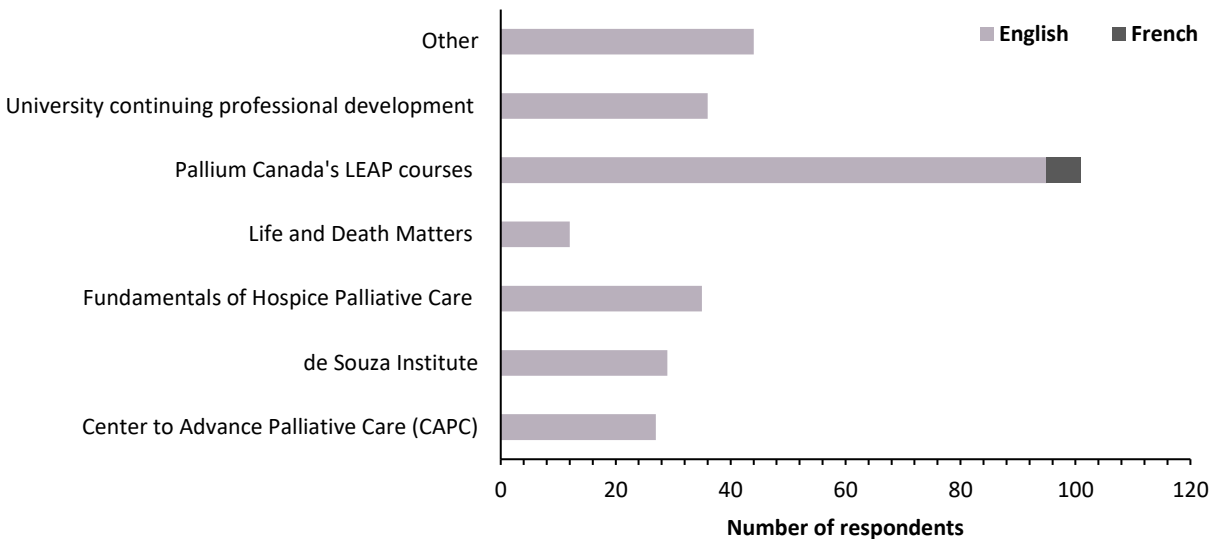
#### **1. Source of information about palliative education resources:**

Respondents reported that they mainly receive information about palliative education resources through advice from colleagues or other professionals (72%), education provider websites (61%; e.g., Pallium/LEAP, de Souza Institute, *Life and Death Matters*), and announcements or notices on conferences/learning institutes/educations days (57%). Other common sources of information included palliative and end-of-life care newsletters (51%), education provider promotional materials (50%), and journals or publications on palliative and/or end-of-life care (39%).



#### **2. Education/training programs used by individuals and organizations**

The most common education/training program used by respondents and their organizations is Pallium Canada's LEAP courses (79% for English respondents; 100% of French respondents).



### ***Preferred learning approaches***

The following section outlines respondents preferred learning approaches and corresponds to survey questions 13 through 17 (See Annex 1). This section includes information on respondents learning preferences/how they prefer to satisfy their education needs, PC education or continuing professional development resource(s) that would help them or their organizations in their work, and useful strategies for advancing PC education in undergraduate and graduate levels, and in continuing professional development.

#### **1. Satisfying education needs**

The top three highest ranked preferences for satisfying education needs were in-person education (e.g., classroom, small group learning workshops), facilitated online learning (e.g., webinars), and a hybrid blend of flipped learning (i.e., combination of online and in-person). Fifty-nine percent indicated in-person education as their highest ranked preference, and between 22-28% of respondents indicated facilitated online learning and hybrid blend of flipped learning as their 2<sup>nd</sup> and 3<sup>rd</sup> highest ranked preferences. Simulations and role play, clinical placements/job shadowing/academic detailing, and hardcopy/printed resources and materials were the lowest ranked preferences for satisfying education needs. Independent online self-learning (e.g., online courses/modules), and electronic resources and materials were ranked in the middle.

#### **2. Preferred education or continuing professional development resource(s)**

Respondents welcome a range of education and continuing professional development resources and opportunities. Overall, respondents seemed to want greater access to information and resources (e.g., handouts, memos, Pallium Palliative pocketbook, booklets/charts with basic information, toolkits),

especially online and at low or no-cost, as well as more learning and training opportunities. Respondents would be interested in attending webinars, panel discussions, and lunch and learns, joining communities of practice (with interprofessional leadership) and journal clubs (particularly on case-based studies), and having access to journals and tools to support best- and evidence-based practices. It was felt by some that the general public as well as patients and their families would benefit from more information and resources around PC.

Respondents emphasized the need for ongoing education (e.g., courses/modules) that is online, self-paced, and low or no cost with hands-on learning/training opportunities (e.g., mentoring, placements) led by PC physicians/specialists. LEAP training that is tailored to profession (e.g., oncologists, undergraduates), area of work (e.g., spiritual care, home care, primary care), disease (e.g., cancer and non-cancer), and patient population (e.g., First Nations communities) was suggested by many. Respondents also felt strongly that PC should be built into education curriculum and training programs so that all HCPs receive basic PC training and have more opportunities to translate knowledge into practice. One respondent noted: *“Honestly, I don't know if MORE education is the answer, but rather how to imbed what is being taught into everyday practice so it sticks and can be provided to the patients and families”*. Specific education and training on a range of topics/areas were identified: communication/conversations (e.g., serious illness conversation guide, debunking myths), pain and symptom management (e.g., on-time training, palliative sedation, dyspnea), GOC and ACP, MAID, health care consent, providing PC across different settings, and collaborating with other HCPs/professionals (e.g., researchers, community nurses).

For staff/professionals to be able to attend educational and training sessions, respondents noted that they required support from their health authorities/organizations/managers, and ultimately, dedicated, and paid time for education and training. For greater uptake, respondents also recommended that sessions be built into their schedules and held on-site.

### **3. Strategies to advance palliative care education**

**Undergraduate and postgraduate:** The most useful strategies identified by respondents to advance PC in both undergraduate and postgraduate education were more hands on learning opportunities (i.e., mandatory rotations and clinical days in PC settings), and the incorporation of PC education into mainstream curriculum with courses/electives/lectures offered on specific topics. Respondents also suggested that more mentorship opportunities (particularly for postgraduates) and mandatory LEAP training prior to graduation would be helpful. Respondents recommended mandatory clinical rotations/placements, in a range of settings, and mentorship programs/opportunities to expose learners to PC/EOL situations and see care modelled in real life. Respondents also indicated that basic information on PC/EOL care and its importance should be part of all undergraduate/entry-to-practice and postgraduate curriculum. Although medical residents were most often mentioned in the comments, there was a strong sense that PC/EOL educational and training opportunities should be incorporated into all HCP undergraduate and postgraduate programs. Disease-oriented curricula, ACP, GOC, serious/difficult conversation training, symptom and pain management were important areas of focus. Respondents noted that more time, funding, and interest in PC are critical to improving PC education and training in undergraduate and postgraduate education.

**Continuing education and professional development:** Respondents welcome continuing education/professional development opportunities. In particular, they welcome a variety of delivery modes (e.g., conferences, workshops, webinars, online videos and tutorials/modules) with communication-focused (e.g., having difficult conversations and having early conversations) and PC/EOL basics and importance as topics for educational offerings. Many respondents recommended LEAP training for all HCPs. Respondents noted that cost, human resources, backfill, and accessibility are issues in participating in continuing education and professional development opportunities. To increase uptake, respondents emphasized the need for greater managerial support and staff to help cover/backfill and recommended that education and training opportunities be offered at low or no-cost and in a convenient time and place (either online or in-person).

Across undergraduate and postgraduate education, and continuing education/professional development opportunities, there seemed to be consensus that awareness of the importance of PC remains low, and that the buy-in and support of health authorities and organizations in promoting a PC approach is much needed. Respondents noted that all HCP should receive basic education and training in PC/EOL, and that content creation and delivery should be done by experts (i.e., those who are working in and providing PC/EOL care).

## Recommendations to Sector

Based on the results of this initiative, the QELCCC offer the following recommendations to the sector to help meet PC education and training needs across Canada:

1. Identify flexible solutions to integrate basic PC content into schools of medicine, nursing, and allied schools of health.
2. Develop resources and offer education and training that reflect the diverse views/needs of different cultural and ethnic groups, and rural and remote communities across Canada to ensure HCPs can deliver PC that is culturally safe/competent, inclusive, and equitable.
3. Develop a range of continuing professional development offerings that include distance and face-to-face options (e.g., workshops, webinars, conferences), synchronous and asynchronous (self-paced) learning. These should include:
  - Interprofessional and interdisciplinary learning opportunities;
  - Information on basic PC principles, pain and symptom management, communication and having difficult conversations, managing the needs of patients and their families, and providing grief and bereavement support.
4. Help HCPs identify learning pathways and connect them to relevant content to meet their individual learning needs – regardless of whether they have already taken PC education or are new to PC.
5. Cultivate the development of interprofessional and cross-setting communities of practice to promote greater collaboration among sectors and communication between HCPs, and increase the shared body of knowledge and awareness of PC.
6. Develop quality improvement initiatives to support putting into practice what HCPs have learned in their PC training (e.g., identifying patients who could benefit from a PC approach earlier).
7. Promote experiential learning and training opportunities for students in undergraduate and postgraduate programs (e.g., mandatory rotations/clinical placements).
8. Promote mentorship opportunities between novice and experienced PC providers.



9. Provide financial support and educational time backfill to support learner participation in continuing professional development opportunities.
10. Provide foundational training in PC for health care leaders and administrators.

## Annex 1: English Survey questions

### Taking Stock: Determining Palliative Education and Training Needs in Canada An Initiative of the Quality End-of-Life Care Coalition of Canada's Education Committee

Many quality resources exist to ensure health care professionals have the skills and knowledge they need to support the best palliative care for people facing life-threatening or life-limiting illnesses. This survey is designed to help paint a clear picture of where gaps in knowledge may exist. By completing this survey, you are helping us to take stock of where current and future learners may need more information, training, tools and resources, so we can help to address those gaps.

For the purposes of this survey, “palliative care” relates to the needs of patients with serious illnesses. It includes palliative care delivered across the illness trajectory, from earlier in the illness to end of life (EOL), and grief and bereavement.

The term “education” is used in this survey to denote learning across the learning journey, from undergraduate and postgraduate education to continuing professional development. The latter includes workforce training and preparedness.

#### ***I. Please tell us about you:***

1. Which of the following describes your work setting(s)? Select **all** that apply:
  - a. Hospital
  - b. Long-term care facility
  - c. Home- and Community-based care
  - d. General practice/Family health team
  - e. Hospice
  - f. Professional association
  - g. University/Academic institution
  - h. Other: \_\_\_\_\_ [if selected, text box appears with ‘Please describe’ as prompt]
  
2. Which of the following describes your work role(s)? Select **all** that apply:
  - a. Health care provider
  - b. Health care leader
  - c. Health care administrator
  - d. Education lead or coordinator
  - e. Educator/Trainer
  - f. Researcher
  - g. Other: \_\_\_\_\_ [if selected, text box appears with ‘Please describe’ as prompt]
  
3. Which of the following **best** describes your profession?
  - a. Physician
  - b. Nurse
  - c. Personal Support Worker/Aide/Attendant



- d. Pharmacist
  - e. Occupational Therapist
  - f. Physiotherapist
  - g. Respiratory Therapist
  - h. Paramedic
  - i. Social Worker
  - j. Spiritual Care Provider
  - k. Health Care Administrator
  - l. Researcher
  - m. Other: \_\_\_\_\_ [if selected, text box appears with 'Please describe' as prompt]
4. If you have an educational role, please indicate what level it pertains to; select **all** that apply:
- a. Undergraduate
  - b. Postgraduate
  - c. Continuing Professional Development/Continuing Medical Education
  - d. Other: \_\_\_\_\_ [if selected, text box appears with 'Please describe' as prompt]
5. Which province or territory do you work within?
- a. Alberta
  - b. British Columbia
  - c. Manitoba
  - d. New Brunswick
  - e. Newfoundland and Labrador
  - f. Northwest Territories
  - g. Nova Scotia
  - h. Nunavut
  - i. Ontario
  - j. Prince Edward Island
  - k. Quebec
  - l. Saskatchewan
  - m. Yukon
  - n. My work is **Pan-Canadian**
  - o. I work outside of Canada. [thank and terminate survey with message 'Thank you for your interest. This survey is intended only for those currently working within Canada.']
6. How long have you been working in health care?
- a. Less than 1 year
  - b. 1-5 years
  - c. 6-10 years
  - d. 11-15 years
  - e. 16-20 years
  - f. 21-25 years
  - g. 26-30 years
  - h. Over 30 years

**II. Please tell us about your understanding of the knowledge and training needs pertaining to palliative care:**

7. In your setting, with respect to palliative care, what do you think are **some** of your or your organization's education priorities in terms of areas/themes and targeted learners?
8. Please complete the sentence: **Right now**, with respect to being able to provide palliative care to patients who need it, my or my organization's **most significant** education need is:
9. **In the future**, what palliative care-related gaps do you anticipate will exist for primary or generalist-level health care workers (i.e., non palliative care specialists) caring for patients with serious illnesses? Please **describe**:
10. What gets in the way of your ability to meet your or your organization's palliative care education needs? Select **all** that apply:
  - a. Direct costs of education or training (e.g., registration fees, etc.)
  - b. Indirect costs of delivering training (e.g., food, travel, teachers, etc.)
  - c. Lack of budget
  - d. Lack of time
  - e. Need to arrange backfill
  - f. Other knowledge/training priorities
  - g. Not a large part of my role
  - h. Other: \_\_\_\_\_ [if selected, text box appears with 'Please describe' as prompt]
11. Where do you or your organization **mainly** obtain information about palliative education resources from? Please select **all** that apply:
  - a. Advice from colleagues or other professionals
  - b. Announcements or notices on Conferences/Learning Institutes/Education Days
  - c. Palliative and end-of-life care newsletters (e.g., Canadian Hospice Palliative Care Association, provincial/territorial organizations, etc.)
  - d. Education provider websites (e.g., Pallium/LEAP, de Souza Institute, *Life and Death Matters*, etc.)
  - e. Education provider promotional materials (e.g., Pallium/LEAP, de Souza Institute, *Life and Death Matters*, etc.)
  - f. Journals/palliative and/or end-of-life care publications
  - g. Other: \_\_\_\_\_ [if selected, text box appears with 'Please describe' as prompt]
12. How do you **prefer** to satisfy your education needs? Please **rank** the following by preference:
  - a. In-person education (e.g., classroom, small group learning workshops) – when pandemic restrictions lifted
  - b. Facilitated online learning (e.g., live webinars)
  - c. Independent online self-learning (e.g., online courses/modules)
  - d. Hybrid, blend of flipped learning (combination of online and in-person)
  - e. Simulations and role play

- f. Clinical placements/job shadowing/academic detailing
  - g. Electronic resources and materials
  - h. Hardcopy/printed resources and materials
  - i. Other: \_\_\_\_\_ [if selected, text box appears with 'Please describe' as prompt]
13. Please share what education/training programs have been used by you or your organization. Please select **all** that apply:
- a. CAPC (Center to Advance Palliative Care)
  - b. de Souza Institute (e.g., iEPEC-O)
  - c. Fundamentals of Hospice Palliative Care
  - d. *Life and Death Matters*
  - e. Pallium's LEAP courses
  - f. University Continuing Professional Development
  - g. Other: \_\_\_\_\_ [if selected, text box appears with 'Please describe' as prompt]
14. What specific palliative care education or continuing professional development resource(s) would further help you or your organization in their work (i.e., information, training, tools, resources, journal clubs, research, etc.)? Please **describe**:
15. What would be the most useful strategies (up to three) to advance palliative care education in undergraduate education?
16. What would be the most useful strategies (up to three) to advance palliative care education in postgraduate education?
17. What would be the most useful strategies (up to three) to advance palliative care education in continuing professional development?
18. Any further comments, ideas, suggestions you would like to share with regard to palliative care education in Canada?

**Thank you very much!** Your answers will help to enhance palliative care education and training in Canada.