

2006). It is associated with feelings of loss of autonomy, loss of dignity, loss of meaning and worth. Patients may also describe fear of death, hopelessness, helplessness, a sense of burdening others, a sense of isolation, sometime a feeling of betrayal. Although they should not be confused, existential distress is often associated with psychological distress. When the former refers to patient's personal values, beliefs, social and familial environment, the latter is more related to psychopathological mechanisms. However, both are deeply interconnected and sometimes hard to distinguish, for example in the wish to hasten death or in patients' requests for sedation (Guerrero-Torrelles 2017).

Existential and psychological distress of palliative care patients contribute to the high levels of moral distress reported in palliative care providers (Maffoni 2019), alongside with difficult professional relationships and organisational constraints. Indeed, while responding to the physical distress makes it possible to rely on a collective (the palliative care team) and on objective (scientific) data, existential suffering mobilizes the carers in their individuality and reaches them in the most intimate dimension of their experiences, beliefs, or convictions. For the clinicians, being aware of this impact and recognizing their own feelings, emotions, representations are of a paramount importance to understand their possible effect on the patient-physician relationship and the therapeutic decisions. Moreover, while clinicians' distress is a subjective experience that negatively impacts quality of life and job satisfaction, it is also a biological one: for instance, short-term adjustment to the demands of the environment can create immediate stress response with increased sympathetic activity; long term adjustment with emotional exhaustion is linked with changes in cortisol metabolism (Fernandes-Sanchez 2018). Understanding how the distress of the patients and clinicians are intertwined is therefore essential.

This presentation will also consider these patients-clinicians' interactions in the specific context of the wish to hasten death and of the medical aid in dying. For example, in France, where euthanasia is still illegal, French Law (so-called Claeys-Leonetti Law) allows the access to Continuous Sedation Until Death for end-of-life patients with refractory and unbearable psycho-existential distress. However, the process of diagnosing the refractory nature of psycho-existential distress remains ill defined; and the fact that it is unbearable has to be appreciated by the patient himself and must not reflect the doctor's limitations or exhaustion. Due to their own distress, clinicians may overestimate or underestimate the patient's suffering (Stiefel 2017); this has some potential ethical consequences on their ability to identify and respect patients' wills and expectations.

Suppression of the clinicians' inner moves is neither possible nor necessary. Being aware of them is however, needed to make therapeutic choices that meet patients' expectations and needs as adequately as possible. Re-integrating these intrapersonal experiences in a collective dimension such as the one permitted by supervision groups and training in patient-physician relationship has also proven to be effective. Existential distress is a part of palliative care: being able to deal with this issue is a condition both of quality care and the good health of the professionals.

## P2-4 DISCOURSES ON DEATH AND DYING AND THEIR EFFECTS ON PALLIATIVE CARE

Camilla Zimmermann. *University of Toronto, Canada*

10.1136/spcare-2023-SCPSC.21

Palliative care originated in the hospice movement, which began in the 1960's and 70's in the United Kingdom, and spread quickly worldwide. This movement was directed broadly against medical and societal 'denial' of death. It was asserted that this denial of death resulted in three main ills: a taboo on conversation about death, the medicalization of death, and the segregation of the dying from the rest of society. This movement resulted in many successes for the care of patients with terminal or life-threatening illness, including the creation of the hospice benefit in the United States; the proliferation of residential hospices and palliative care programs; and the founding of the specialty of Palliative Medicine. However, the broader aim of changing the culture of denial surrounding death was less successful. Indeed, tying palliative care to acceptance of dying created a situation where those who were not acceptant (and perhaps could most benefit from psychological help from palliative care) were not reachable. In order to reach this population, the field of hospice and palliative care had to change.

The main change in the focus of palliative care was its progression 'upstream' to encompass care at earlier stages of the illness trajectory, rather than focusing only on care at the end of life. This change was formalized by a new palliative care definition by the World Health Organization in 2002. Resulting changes in the field of palliative care included expansion to the outpatient setting and from cancer care to illnesses with a less certain prognosis; integration of palliation with treatments aimed at cure; and training of non-specialists to integrate primary palliative care into routine practice. These reforms in palliative care were met mostly with enthusiasm by the medical community, particularly as they were corroborated with evidence from randomized trials that earlier involvement of palliative care improves quality of life.

In contrast, the public has largely not kept up with the evolution of palliative care. Instead, the label of the specialty that deals with the dying patient has stuck fast. This is a problem that palliative care will need to deal with if it is to reach those who do not wish to accept that they are dying. Some services have reacted by renaming their service 'supportive care', others have embedded clinics within oncology, still others have created automatic referral services or care pathways. The success of these endeavours remains to be determined. In addition, the populist movement in favour of physician-assisted suicide has gained ground, and in some countries including Canada has resulted in full legalization. This movement represents a discourse that has disrupted the traditional dichotomy of acceptance and denial of death, and will undoubtedly influence the further evolution of palliative care.

In sum, palliative care is linked inextricably to discourses on death and dying. The hospice movement sought to change

societal attitudes toward death; however it can be argued that instead, these attitudes have persisted and have shaped the evolution of palliative care.

## Plenary Session 3

### Technology-enabled care (TEC) in palliative care

#### P3-1 MEDICAL DIGITAL TRANSFORMATION AFTER COVID-19: INDUSTRY 4.0 AND HEALTHCARE

Fumiaki Ikeno. *Stanford University, USA*

10.1136/spcare-2023-SCPSC.22

The once-in-a-century pandemic has changed the world in many ways. In the U.S., which suffered the most damage, people were forced to use non-contact medical care, especially in the medical field, and as a result, various medical devices and services using digital technology became a MUST HAVE and spread rapidly. Now that the corona disaster is over, we are not going back to the pre-corona state, but rather, a hybrid of virtual and physical medicine is being developed. For example, telemedicine accounts for more than 50% of family physicians' practice, and U.S. health insurance authorities actively promote day surgery. In addition, the concepts of Virtual Hospital and Medical Home are being introduced to provide hospital inpatient care at home and will be reimbursed by the U.S. health insurance authorities in the fall of 2021. In this way, digital medical transformation using digital technology is advancing rapidly, necessitated by the Corona disaster, and the fourth industrial revolution is taking place in both name and reality. In this article, I would like to introduce the current status of digital technology in the U.S. medical industry.

#### P3-2 INTELLIGENCE AUGMENTATION IN HEALTHCARE PLATFORM—MICROSOFT'S VIEW

Keren Priyadarshini. *Microsoft Asia, Singapore*

10.1136/spcare-2023-SCPSC.23

Medical science has improved rapidly, raising life expectancy around the world, but as longevity increases, healthcare systems face growing demand for their services, rising costs and a workforce that is struggling to meet the needs of its patients. By 2050, one in five people in Asia will be over the age of 65 which implies that the health systems will have to deal with more patients with complex needs. Managing such patients with co-morbidities would require systems to shift from an episodic care-based philosophy to one that is long-term care management.

The World Health Organisation has projected a shortfall of 9.9 million physicians, nurses and midwives globally by 2030 thus accentuating the need to attract, train and retain more healthcare professionals.

Over the past few years, the healthcare industry has made a strong case for the use of artificial intelligence to augment

clinical decision-making to improve patient outcomes. Augmented Intelligence (AI) systems have the power to transform health care and bring us closer to the quadruple aim: enhancing patient experience, improving population health, reducing costs, and improving the work life of health care providers. Earning physicians' trust is critical for accelerating adoption of AI into patient care. As technology evolves, the medical community will need to develop standards for these innovative technologies and re-visit current regulatory systems that physicians and patients rely on to ensure that health care AI is responsible, evidence-based, free from bias, and designed and deployed to promote equity.

While the number of AI systems used in health care has increased exponentially in recent years and numerous frameworks for ethical use and development of AI have been proposed, there is still no consensus on guiding principles for development and deployment of AI in health care. To harness the benefits that innovative technologies like AI can bring to health care, all stakeholders must work together to build the evidence, oversight, and infrastructure necessary to foster trust.

#### P3-3 TELEMEDICINE, ARTIFICIAL INTELLIGENCE, AND DIGITAL THERAPEUTICS: RISE OF THE ROBOTS OR THE FUTURE OF COMPASSIONATE CARE?

Mihir M Kamdar. *Massachusetts General Hospital, USA*

10.1136/spcare-2023-SCPSC.24

Palliative care finds itself in a conundrum. Our field is rapidly growing, and yet in the coming decades, the need for palliative care in most countries will far outpace the number of specialist clinicians available to provide it. Hence, it is imperative that we develop novel care delivery models in the present to address the needs of our future patients. Telepalliative care, digital therapeutics and artificial intelligence represent innovative means to help extend the reach of palliative care. Telepalliative care is the practice of providing palliative care using technology to deliver care at a distance, often through video platforms. Digital therapeutics (DTx) represent an expanding field of evidence-based healthcare interventions that utilize everyday technology, such as mobile apps, online platforms, and wearable devices to augment care delivery. Artificial intelligence (AI) involves the use of adaptive algorithms to perform tasks which typically require human cognition. If harnessed thoughtfully, telepalliative care, digital therapeutics, and AI can make palliative care more effective, efficient, and expansive. This session will examine the numerous possible benefits and barriers of integrating telemedicine, DTx, and AI into palliative care. Drawing on experience from operationalizing a large, multisite telepalliative care RCT and the COVID-19 pandemic, we will discuss the opportunities, challenges, and nuances of palliative care delivery via telemedicine. We will explore how digital therapeutics can be used to better address symptom management and help initiate advanced care planning through case examples. Through discussions on machine learning, we will learn how AI can better identify patients who can benefit from palliative care. We will discuss how telepalliative care, DTx, and AI can simultaneously improve patient outcomes, reduce clinical burden, and paradoxically bring patients closer to us.