

at the time of death. Levetiracetam was the most utilised anti-convulsant at end-of-life (N=9). All patients saw a physiotherapist during their admission. Rates of referral to other members of the interdisciplinary team varied. The most common theme in the psychosocial domain was a mismatch between escalating care requirements from progressive functional decline and capacity to meet these needs in the home environment.

Conclusion Preliminary results highlight the high symptom burden and challenging neurological decline faced by patients with primary brain tumours. It emphasises the importance of early palliative care involvement in addition to multidisciplinary delivery of holistic support to patients and caregivers.

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OP-5 A NOVEL CURRICULUM: INCORPORATING TRANSFORMATIVE LEARNING THEORY-BASED NARRATIVE MEDICINE MODULES INTO PALLIATIVE CARE PHYSICIAN TRAINING

Pramita Kuruvilla*. *University of California, San Francisco (UCSF), San Francisco, USA*

10.1136/spcare-2024-ANZSPM.5

Background Narrative Medicine is a powerful tool that helps learners in training critically reflect on experiences that significantly impact their learning journey. The term ‘narrative medicine’ is attributed to Rita Charon, MD, who characterized it as ‘medicine practiced with narrative competence...such as close reading of literature and reflective writing.’¹

Since its beginnings as a field, Palliative Medicine has emphasized whole personhood in the clinical encounter. Conceived by a social worker, nurse, and doctor in the form of Dame Cicely Saunders, the nature of palliative medicine focuses on each patient’s humanity and the value of hearing

their lived experiences.² This ethos aligns beautifully with Narrative Medicine, which ‘draws on the study of art and literature to enhance students’ listening and observation skills and to expand their view of patients to encompass more than just medical histories.’³ In both Narrative and Palliative Medicine, patients are recognized for being more than their diagnoses; their stories matter.

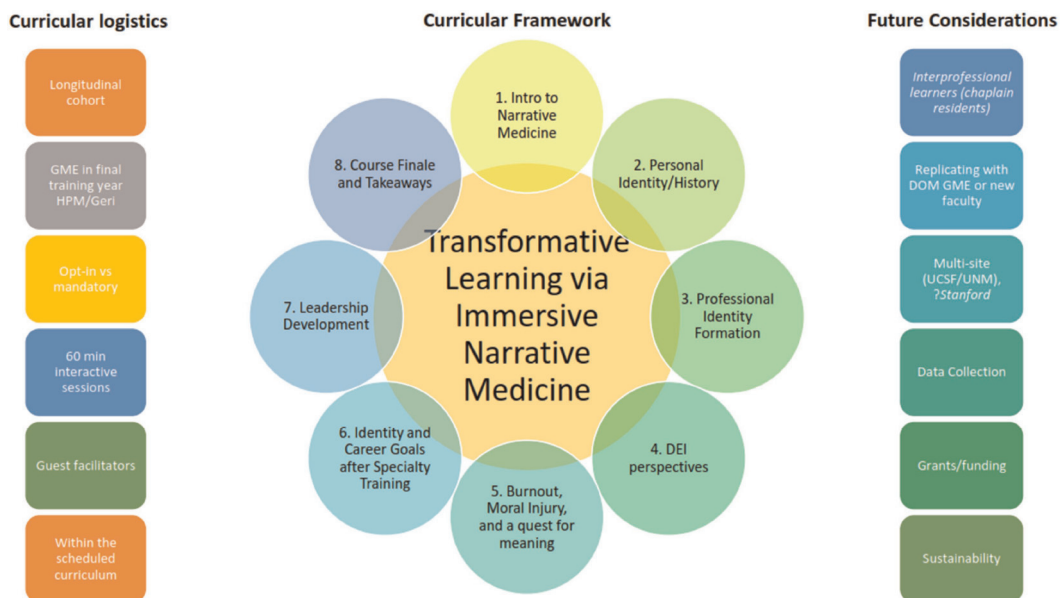
The Journal of Pain and Symptom Management recently published an article opining that ‘narrative medicine is the missing ingredient in palliative care training that will allow learners to engage more consciously and fully with their patients, and develop excellent habits of resilience and coping.’⁴

In this presentation, we will share details and preliminary feedback of a Palliative Medicine curriculum pilot incorporating Narrative Medicine using a Transformative Learning theory.⁵ Physician learners at UCSF examine essays, art, and poetry that focus on intersectional topics in palliative medicine, utilizing the awareness raised from these works to critically reflect and create new paradigms of understanding. Just as patients in the clinical encounter find empowerment and healing by sharing their narratives, we hope that learners, through reading and reflecting via narrative medicine, can find greater connection, meaning, and empathy.⁶

Objective 1: Design an innovative Narrative Medicine curriculum for Physician Learners to raise awareness, connection, meaning, and empathy.

Objective 2: Illustrate the natural synchronicity of utilizing Narrative Medicine as a tool in furthering Palliative Medicine Curriculum Development.

Conclusion Palliative Medicine and Narrative Medicine share an ethos of valuing individual perspectives and intersectional positionality. Just as patients find empowerment and healing by sharing their narratives, we hope that learners, through narrative medicine, can find greater connection, meaning, and empathy. We will share preliminary results of a Palliative Medicine curriculum pilot incorporating Narrative Medicine using Transformative Learning theory (figure 1).



Abstract OP-5 Figure 1

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OP-6 COMMUNITY PHARMACY ENGAGEMENT IN PALLIATIVE CARE

¹Peter Allcroft*, ²Paul Tait, ³Michaela DelCampo. ¹Commission On Excellence In Innovation And Health, Adelaide, Australia; ²Rural Support Service South Australia, Adelaide, Australia; ³Central Adelaide Local Health Network, Adelaide, Australia

10.1136/spcare-2024-ANZSPM.6

Access to injectable medicines in the community is crucial for people wishing to die at home. Previous surveys in South Australia in 2012 demonstrated only 6% of pharmacies were able to facilitate medication provision to support dying at home. Following SA State Government funding in 2023 for 30 community pharmacies across SA to stock vital medications to support terminal phase symptom management in the community, we undertook a follow up survey to assess if there had been an improvement in the number of pharmacies who stock medications for symptom management at end of life.

An electronic survey was sent to all 499 registered pharmacies in South Australia via email with reminder follow up emails on 2 occasions. Data included postcode location which enabled an understanding of Socioeconomic Indexes for Area (SEIFA) quintiles of the respondents. The survey asked about medications held to provide symptom management for commonly encountered end of life symptoms. The 'preparedness score' (Range 0–5) was calculated as 1 point for each medicine held. Ethics approval was provided by SA DHW HREC.

Despite a low response rate of 41/499 pharmacies (8.2%), the respondents represented the distribution across SEIFA quintiles, and metropolitan and rural locations. While 23/41 (56%) held a valuable range of formulations, 12 (29%) stocked no medications to manage end of life medications. The 23 pharmacies with a preparedness score of 5 were in regional SA, higher sociodemographic regions, were linked with a Residential Aged Care facility and were aware of patients with palliative care needs in their area.

Whilst the response rate was poor, it appears that when compared to 2012, there has been an improvement in the number of pharmacies holding critical medications for end-of-life care at home. Strategies to improve the engagement of community pharmacies to stock medications used for end-of-life care is important. A 3-way co-operation between the pharmacist, General Practitioner and Specialist Palliative Care services would seem to be a good starting point by raising the awareness of potential patients to ensure stock is on hand. Strengthening these partnerships will help to care for people at home, and potentially reduce the impact on the acute care hospital sector. Further governmental support is critical to ensure policies and funding are directed to improving the care

for people with life limiting illness to remain at home for end-of-life care if that is their preference.

OP-7 THE TIMING OF OPIOID INITIATION AND SWITCHING IN ADVANCED CANCER

^{1,2,3}Aaron K Wong*, ^{1,3}Dorothy Wang, ²Ian Gordon, ¹Marliese Alexander, ¹Beverly Siew, ^{1,3}Natasha Yap, ^{1,2,3}Brian Le, ^{1,2,3}Jennifer Philip. ¹Peter MacCallum Cancer Centre, Melbourne, Australia; ²University of Melbourne, Australia; ³The Royal Melbourne Hospital, Australia

10.1136/spcare-2024-ANZSPM.7

Background Cancer pain guidelines call for early opioid initiation. However, the timing of opioid initiation in relation to advanced cancer diagnosis has not been elucidated. The most frequent opioid used differs according to country and region, and the timing and frequency surrounding opioid switching in Australia also not been clearly documented. The role of palliative care teams in initiating opioids for advanced cancer is also unclear.

Aim To determine the timing of opioid initiation and switching by prescriber and cancer type, in relation to key time-points in the cancer illness course (diagnosis, palliative care referral, and death).

Design Retrospective cohort study.

Setting/Participants Patients at a quaternary cancer centre diagnosed with incurable advanced biliary/liver, colorectal, lung, renal/bladder, and pancreatic cancers between 1 August 2020 – 1 August 2022 were eligible. Demographics, clinical characteristics, health service use, and details of longitudinal slow and immediate release opioid prescriptions are reported.

Results Among 200 patients, median time from advanced cancer diagnosis to first immediate release opioid prescription was 23 days (IQR 1, 82) and to slow release opioid prescription was 47 days (IQR 14, 155). Most patients (95%, n=190) were referred to palliative care (median time to referral 54 days (IQR 18, 190)). Non-palliative care prescribers initiated slow release opioids for half of participants (49%, n=97) prior to referral. Patients with pancreatic cancer had earliest time to slow/immediate release opioid prescription (median 10 days (IQR 0, 39) and 26 days (IQR 1, 43) respectively) and shortest survival (median 136 days (IQR 82, 214)).

Over half (58%) patients underwent opioid switching at least once. Of these, approximately two-thirds switched due to uncontrolled pain or adverse effects and the remainder switched due to need to use a separate route for clinical reasons. Over a quarter (28%) switched opioids twice and 8% switched three times. The opioid dose threshold for switching appeared to be almost always approximately double of the opioid starting dose.

Discussion/Conclusions Time from diagnosis of advanced cancer to opioid commencement is short (median 3 weeks). Therefore people with advanced cancer require early pain intervention and management within the first month after diagnosis. Median time from opioid commencement to death was 4 months and this may mitigate patient and prescriber concerns around opioid tolerance and dependence which often develop over longer time periods.

Opioid switching is more common in our centre compared to the available data published in Europe. Potential reasons for this will be discussed. Time to opioid initiation varies according to cancer type, suggesting a difference in pain