How to write a great conference abstract

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Your abstract is your first and best opportunity to make a strong impression. It's the key to convincing reviewers that your work deserves a spot on stage and attracting delegates to your session. A well-written abstract can make all the difference.

Why your abstract matters

Most conference abstracts are reviewed blind, meaning all identifying information is removed to ensure unbiased evaluation. With limited spots available and a competitive selection process, your abstract must stand out as both high-quality and relevant.

Preparing your abstract

Understand the guidelines

- Review the submission instructions for word count, presentation type, and themes.
- Ensure your abstract aligns with the conference's focus.
- Contact organisers if you have any questions—don't let unclear instructions hold you back.

Learn from examples
Read abstracts from past conferences, like the examples from 23OPCC, to see how others have effectively structured their ideas.

What to include

A strong abstract typically includes:

- **Background**: What is your paper about?
- **Aim**: Why is it important?
- **Methods**: How did you conduct your work?
- **Results or outcome**: What did you find?
- **Conclusion**: Why does it matter?

Writing an engaging abstract

Be clear and concise

- Use plain English and avoid jargon or overly complex words.
- Focus on communicating your ideas clearly.

Demonstrate enthusiasm

- Show your passion for the topic – tell us why you're excited about your work
- Highlight why your session will engage and inspire the audience.

Test readability

- Read your abstract aloud to check its flow and clarity.
- Share it with a colleague to ensure it's understandable and interesting.

Polishing your abstract

1. **Start early**
    - Give yourself time to write, revise, and refine your abstract so you avoid the stress of last-minute submissions.
2. **Check for errors**
    - Proofread for spelling, punctuation, and grammar.
    - If writing isn't your strength, ask someone else to review it.
3. **Seek feedback**
    - Share your draft with peers or mentors.
    - Incorporate their suggestions to improve your submission.

Final thoughts

Your abstract is more than a summary—it's a pitch for why your work matters. Take the time to craft a submission that meets the guidelines and captures the interest of reviewers and attendees. With thoughtful preparation, your abstract can secure your place on the conference stage.

Examples of conference abstracts

Example 1

Challenging perceptions, building paramedic capacity and embracing integrated models of care: Findings from a mixed-methods PhD exploring the role of paramedics delivering palliative and end-of-life care in Australian communities

Background: Paramedics are a highly skilled and unique workforce, attending to patients in the community 24/7 across all locations. As global populations age and community preferences to die at home increase, new models of paramedic practice are required to respond to the growing needs of palliative care patients, especially out-of-hours.

Aim: To explore the role of paramedics delivering palliative and end-of-life care in Australian communities and develop a palliative paramedicine framework suitable for national implementation.

Methods: Four empirical studies were undertaken: (1) systematic integrative review; (2) comparative clinical practice guideline analysis; (3) qualitative interviews; (4) Delphi study.

Setting, data collection and analysis: 22 studies were thematically analysed for the systematic review. Eight palliative care guidelines from Australian, New Zealand, UK and Canadian ambulance services were quality appraised, and content analysed. 50 Australian paramedics', palliative care doctors' and nurses', GPs', residential age care nurses' and bereaved family members' experiences and perspectives were thematically analysed. Consensus regarding essential framework components was gained from 70 Australian and international palliative paramedicine experts.

Results/findings: Participants reported and supported a role for paramedics in providing emergency support to patients approaching end-of-life, facilitating home-based deaths and reducing avoidable hospital admissions. They felt many existing paramedic skills can be leveraged to suit the palliative care context but reported challenges in this setting. Paramedics expressed vulnerability when taking this approach to care, and require additional training, support and clinical back-up. Components gaining consensus from the expert panel for inclusion in the framework will be reported.

Conclusion/lessons learnt: Strong consensus exists amongst experts that a multi-faceted framework is required to address the structural, service, community and individual factors influencing practice. Implementing this framework, in partnership with ambulance services and the palliative care community, will aim to standardise best practice and strengthen a culture of interdisciplinary palliative care across Australia.

Example 2

Keeping on speaking terms: building autonomy of allied health communication with primary care

Background: Allied health professionals have a key role in the care of people receiving palliative care. To date, this role has largely been concentrated within acute care, with allied health expertise and intervention often not directly communicated to patients' primary care providers. Embedding the principles and design of integrated care to promote shared expertise and communication in models of care. Consideration of intersectionality of integrated care principles and service delivery can define new opportunities in multidisciplinary models of care.

Objective: To implement a new integrated and holistic model of care, the 'Palliative Care Multidisciplinary Ambulatory Clinic' which incorporates comprehensive allied health assessment, care planning and communication with patients' primary health care providers pre and post review. Approach: Palliative Care Multidisciplinary Ambulatory Clinic was implemented at a metropolitan general hospital in January 2023 after 8-months of planning. Led by social work, the team includes a clinical nurse consultant, exercise physiologist, physiotherapist, and occupational therapist. One week prior to the patient's first appointment, the social worker formally notifies the primary health provider of clinic appointment and requests contribution to guide assessment. During the patient's first two-hour clinic appointment he/she is reviewed by four to five allied health professionals, who each contributes to a primary health care plan. This plan is then communicated to the patient's nominate primary health provider within three days.

Findings: In the first two months, the Palliative Care Multidisciplinary Ambulatory Clinic assessed 10 patients and developed 10 care plans, 100% of which were communicated to the primary care provider within three days. Patients were referred to 21 specialist services, after rapid case conference during the clinic time.

Conclusion: The new Palliative Care Multidisciplinary Ambulatory Clinic demonstrates how specialist palliative allied health care can be provided and integrated into patients' primary care.

Example 3

The SHINE program

SHINE: a rural palliative care patient education initiative

Aim: Early referral to palliative care has been shown to improve outcomes. The SHINE program was developed as an information and education provision initiative targeted at a rural population.

About: The SHINE program is a four-week course for patients and carers diagnosed with a life-limiting illness helping them live life to the fullest and empowering patients with the knowledge to access and utilise support in a rural setting. SHINE included a multi-disciplinary approach with physiotherapists, occupational therapists, social workers, mindfulness specialists, general practitioners and the local outpatient and inpatient palliative care teams. SHINE sessions included energy conservation, carer training, symptom management, advanced care planning, the opportunity to complete legal documents, the role of GP in care, mindfulness, exercise programs, information about the service and the chance to connect with other patients undergoing similar experiences. Group size was limited to a maximum of 14 for a more personal holistic experience. Local volunteer group support was obtained, and consultation was sought to ensure cultural sensitivity for participants.

Results: On completion, the patient feedback survey included the following: “I thought I was alone caring for my husband; now I have support. Thank you for this opportunity.” Meeting the palliative care teams was great; I now understand their role and how to receive a referral from my GP. It was great to see the available services and feel comfortable contacting them”. The OT energy conservation talk was brilliant, it has changed my life.” “I enjoyed getting to know other people and sharing experiences. I didn’t realise how much I didn’t know.” The program's success was confirmed through the collection of pre-and post-outcome data.

Conclusion: Patient and carer empowerment and understanding may be enhanced in small group sessions within a rural community to improve palliative care outcomes.