treatment. Assessment of symptoms as well as treatment are challenging as pharmacologic approaches must consider the treatment, interactions with treatment as well as long-term impact on the patient. The benefits of such advances are dramatic, so too are the challenges for palliative care providers.

Despite the increased prevalence of cancer survivors and those living with cancer, data regarding pain in this population is lacking but purported to be between 16 and 50%. Chronic pain in this population is often neuropathic; CIPN appears to be on the rise. Cancer pain is complex—due to tumor, anti-neoplastic therapies, associated nerve damage as well as local and generalized inflammation. Tumor related factors and responses such as cachexia, fatigue and nausea often reinforce pain syndromes. Cancer pain does not follow non-malignant trajectories; assessing and treating pain in survivors is similarly unique. There is limited evidence for pain treatment in this population; however, long-term use of opioids and adjuvant analgesics have both known and unknown consequences.

Cancer survivors demand surveillance—a multidisciplinary team and partnerships amongst oncology, palliative care, pain management and rehabilitation specialists are ideal—pain and other symptoms often signal recurrent disease, second malignancy or late onset treatment effects that warrant evaluation, treatment and monitoring. Developing and implementing assessment tools, considering prophylactic therapies prior to treatment and nurturing relationships amongst specialists as well as investigating and utilizing adjuvant, non-opioid therapies is essential in this era of increasing survival.

Substance Use as a Family Disease: Shepherding the Flock Safely Through the End of Life (FR417)

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Objectives

- Identify the importance of creating structure and a 'holding environment' for individuals with substance use disorders (SUDs), in particular during the transition to home hospice.
- Describe how family systems theory can be used to conceptualize and assess the family containing someone with a substance use disorder.
- Describe safety measures used by the hospice team to limit substance misuse and diversion in the home setting.

Opioids have long been a mainstay of symptom management in hospice care, allowing patients with terminal illnesses to have an improved quality of life in the final part of their journeys. Unfortunately, these same medications have contributed to the explosion of the opioid epidemic. As patients with substance use disorders (SUDs) age and develop other life-limiting illnesses, many will be referred to hospice care. For these individuals, opioids used for symptom management can increase suffering due to misuse of medications and addiction. Individuals with SUDs are often dealing with concomitant psychiatric illnesses, coupled with the challenges all individuals face at the end of life, making them particularly vulnerable to chemical coping, escalating misuse, or relapse. Bringing principles of addiction psychiatry and family systems into the home environment can help us safely shepherd individuals through the final part of their lives.

Through case presentations, a review of the literature, and personal experience, we will share with those in the hospice community how individuals and families with substance misuse can be transitioned to home hospice as safely as possible. We will demonstrate screening techniques and language used at initial visits to build trust with patients and families. We will show how the hospice team can set expectations and boundaries for those within their care. We will also describe measures taken to improve the safety of patients, families, and the hospice team while balancing the mission of hospice medicine, addressing total pain at the end of life. Woven into each section will be common ethical challenges encountered by hospice team members during the care of individuals with SUDs.

Beyond Charlie Gard: Rights, Responsibilities and Rational Response in the Realm of Parental Requests for Potentially Non-Beneficial Treatment (FR418)

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Objectives

- Discuss the ethical issues raised by the high-profile case of Charlie Gard, as well as, parental requests for potentially non-beneficial treatment in a broader historical and practical context.
- Discuss multiple perspectives on the complex issues of parental requests for potentially non-beneficial treatment.
- Discuss the potential influence of public opinion and modern media in such cases.

The much-publicized case of Charlie Gard brought the issue of parental requests for potentially non-beneficial treatment (NBT) into the public eye. It is not hard to understand why parents would advocate fiercely for any treatment that could benefit their child. At what point, though, should clinicians decline such requests based on lack of benefit or disproportionate burden? And what role should institutional policies and public opinion have in determining the proper response to such requests?

Using the 2015 ATS/AACN/ACCP/ESICM/SCCM consensus statement on NBT as a framework, this interactive case-based session will examine requests for potentially non-beneficial treatment from clinical, historical, legal, and personal perspectives. After tracing the trajectory of medical decision-making from paternalism to radical autonomy, recent attempts at defining and actualizing the concept of medical futility will be reviewed. Competing notions of burden and benefit will be explored, with specific reference to physicians' well-documented tendency to underestimate quality of life compared to patients and their families. A multi-disciplinary panel will aid in presenting various perspectives, including that of the parents and families. Clinicians' engagement with public opinion will be specifically addressed by a palliative care physician who weighed in about the Charlie Gard case, and will explore the degree to which we assume responsibility in presenting these issues to the public evenly and accurately, as well as the potential pitfalls of modern media. Practical steps—including recommendations for specific language, institutional policies, and mediating measures—will be presented.

"My Family Would Be Better Off Without Me": Managing Suicidal Ideation and Risk in Palliative and Hospice Care (FR419)

David Gruenewald, MD FACP, VA Puget Sound Health Care System, Seattle, WA. Kathleen Bickel, MD MPhil MS, University of Colorado School of Medicine/Rocky Mountain Regional VAMC, Aurora, CO. Jaclyn Schneider, MD, VA WNY Healthcare System, Buffalo, NY. Christopher Parkinson, PhD, Southeast Louisiana Veterans Health Care System, New Orleans, LA. Sumathi Misra, MD MPH CMD FAAHPM, Vanderbilt University Medical Center, Nashville, TN. Lynn Bushor, DNP APRN ACHPN, Veterans Health Administration, Mayfield, KY. Richard Stiles, MSN, Department of Veterans Affairs, New York, NY.

Objectives

- Recognize the high prevalence rate of suicidal ideation, attempts, and completed suicide in Veteran and non-Veteran patients receiving palliative care, and the widespread impact of suicide on survivors including family and professional caregivers.
- Describe validated assessment tools and evidence-based treatments to identify and manage patients at high risk of suicide in palliative care settings.
- Identify actionable strategies to integrate suicide risk assessment and management into clinical practice across various palliative care and hospice settings in Veteran and non-Veteran populations.

People facing serious medical illness often experience significant and debilitating psychological distress in addition to symptoms associated with the underlying disease. While many people are resilient, large epidemiologic studies suggest increased risk of suicide in serious medical illness. For example, in a study of suicide risk and precipitating circumstances in male Veterans >age 65 years, the adjusted odds ratio of suicide was 36-fold higher in those with physical health problems. Suicide in palliative care and hospice patients has not been widely studied, but known suicide risk factors include: older age, history of mental health problems, male gender, social isolation, recent medical hospitalization, poor physical functioning, and access to lethal means including opiates or firearms. Suicidal behavior is more lethal later in life, due to increased frailty, social isolation, greater resolve, and greater likelihood of firearm use.

Despite the high prevalence of these suicide risk factors in palliative care patients, few palliative or hospice programs have routine, standardized screening for suicide risk. Limited data guiding suicide assessment and prevention in palliative care are largely extrapolated from other patient populations. Multiple questions remain, including: should all palliative care and hospice patients be screened routinely for suicide risk? What assessment tools should be used? What warning signs signify especially high risk in this population? What words work best to evaluate risk without detracting from other goals of palliative care encounters? What interventions minimize suicide risk in palliative care patients?

In this concurrent session, our interdisciplinary panel will review current knowledge of suicide risk assessment and prevention across palliative care settings. We will present conceptual frameworks connecting suicidality, interpersonal risk factors, and biopsychosocial-spiritual domains. Then, based on evidence and clinical expertise, we will offer recommendations for assessing and stratifying suicide risk along with suicide risk-reduction strategies adaptable to palliative and hospice care settings.

Palliative Connect: Triggered Palliative Care Consultation Using an EHR Prediction Model (FR420A)

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