they relate to psychological integration and improved prognostic awareness.

- Demonstrate practical techniques and communication strategies to cultivate a holding presence for patients and families.
- Identify key insights from psychodynamic theory that provide a useful framework for optimal psychological coping.

One of the most challenging aspects of hospice and palliative care is encountering a patient’s fear of the dying process, including the common existential worries of dying alone and the losses of physical decline. How does a patient have the psychological strength to go from the security of their previous healthy life to the many phases of loss and uncertainty with life-limiting illness? Recent literature reveals that many patients mitigate these fears by proactively creating a tightknit circle of trusted people "on the inside.” This "inner circle” generally consists of reliable family, loved ones and clinicians who are emotionally available to the patient, but not overly invasive or intrusive.

The "holding presence” of this inner circle allows patients to better tolerate the possibility of dying by facilitating an environment where patients can smoothly vacillate between comfort and fear as well as more and less realistic hopes. This swinging between such extremes is most successful when a patient has secure attachments to this inner circle of relationships that can witness this back and forth. Moreover, this containing presence allows patients to better communicate their values and goals amidst intense affective experiences. Thus, such a holding environment can facilitate improved prognostic awareness and advance care planning.

In this interdisciplinary concurrent session, three experts in psychodynamic theory and palliative care will highlight how the "holding presence” of an inner circle creates a containing environment for patients to better cope with life-limiting illness. One expert is a psychoanalyst and will reveal how contributions from thinkers such as Winnicott, Bion, Bowlby and Buber illuminate these relational dynamics at the end of life. Presenters will draw upon clinical case material to demonstrate practical techniques utilizing these insights when caring for patients and families.

“God Is Able”: Miracles and Hope in Our African-American Patients: Challenges, Historical Perspective and the Way Forward (FR459)

Ronit Elk, PhD, University of South Carolina, Columbia, SC. Kimberly Johnson, MD MHS, Duke University Medical Center, Durham, NC. Alvin Reaves, MD FACP FAAHPM, MedStar Southern Maryland Hospital, Clinton, MD. Gloria White-Hammond, MD, Harvard Divinity School, Cambridge, MA. Shellie Williams, MD, University of Chicago, Chicago, IL. Leigh Vaughan, MD, Medical University of South Carolina, Charleston, SC.

Objectives

- Recognize potential pitfalls and missed opportunities in responding to family members’ communication about their belief that God will perform a miracle and heal their loved one despite medical team’s belief that patient is at the end of life. Gain understanding of both sides of an interaction in which the clinician encounters a terminally ill African-American patient and family who are expecting a miracle; the clinician who feels frustrated and manipulated by the patient/family who are not facing the reality of impending death; the patient and family who feel their beliefs and culture are being entirely disregarded.
- Describe the ongoing challenges and historical context which inform a belief in miracles and emphasis on hope for African Americans across the lifespan, including at the end of life. Gain insight into the concept of “hope and miracles” in the African-American community, from (1) A historical and cultural context and (2) In terms of how it plays out in serious illness.
- Describe communication strategies which demonstrate respect, build trust, and reduce conflict in responding to family’s expression of a belief in miracles in the face of a patient’s poor prognosis. Gain insight into a communication method in which the patient and family’s values of hope and a miracle are respected by the clinician; and the resulting feelings of (a) the patient/family and (b) the clinician.

End of life care in the U.S. has been rooted in values that represent the cultural and religious values of the white middle class. Yet what is perceived and promoted as beneficial for one group may not hold the same value for another groups, with a different frame of reference, value system and life experience. Lack of understanding of, and respect for, the cultural values of others often results in negative consequences for the patient and family. Patients and families whose beliefs and values are not understood or addressed, understandably feel disrespected and devalued, and have to make additional efforts to ensure that the goals of care they wish for themselves/ their loved ones, are followed. Palliative care clinicians often feel frustration when they see a terminally ill patient undergoing “needless” interventions/treatments. In the African-American community the importance of faith, spiritual beliefs and church are key components in understanding and coping with illness, and provide a framework within which treatment decisions are made. African-American families' deep faith in God's healing power, and the belief in hope, both of which directly impact goals of care and treatment preferences, are often misunderstood by clinicians. In this session, participants will gain an understanding into the central relevance of "hope and miracles" in the African-American community, from both a historical and cultural context, as well as how it plays out in serious illness. Illustrations will be provided of ineffective clinician-patient/family communication (resulting in the patient/family feeling disrespected and a frustrated clinical team), as well as positive communication. Take-home lessons for effective culturally-based communication and best practices are provided.

Medical Cannabis in Outpatient Palliative Care: Evidence and Approaches for Integrating Cannabis into Clinical Practice (FR460)

Ali John Zarrabi, MD, Emory University School of Medicine, Atlanta, GA. Kathleen Broglio, DNP ACHPN ANP-BC CPE FPCN, Dartmouth Hitchcock Medical Center, Lebanon, NH. Drew Rosielle, MD FAAHPM, University of Minnesota Health, Minneapolis, MN. Diana Martins-Welch, MD, Northwell Health, New Hyde Park, NY. Ivan Zama, MD, University of Maryland-Prince George's Hospital Center, Cheverly, MD. Jeanne-Marie Maher, MD FACP, Catholic Medical Center, Manchester, NH.

Objectives

- Discuss the current evidence supporting cannabis as a therapeutic strategy for patients with serious illnesses experiencing symptoms that are unrelieved by the standard palliative care toolkit
- Describe strategies for integrating medical cann.abis into your palliative care practice.
- Counsel patients on the benefits and harms of cannabis use, cannabis preparations, delivery systems, and state regulations related to its us.

Increasing numbers of patients living with serious illness are requesting access to medical cannabis as well as guidance about its use. Select palliative care clinics have incorporated cannabis into their therapeutic toolkit, and cannabis consultations have become a gateway to a palliative care assessment and advance care planning. In many states healthcare providers are responsible for counseling and registering patients for medical cannabis, although medical decision-making about the benefits and harms of cannabis is challenging given the paucity of clinical guidelines and evidence, and a wide variety of non-standardized cannabis preparations.

In this session, outpatient palliative care providers who have incorporated cannabis as a therapeutic strategy in their clinics will 1) address the existing evidence regarding cannabis for the treatment of pain, nausea, appetite disturbance, insomnia, and mood disturbances, 2) describe how providers are integrating medical cannabis into their palliative care practices, and particularly how providers are using cannabis to reduce opioid and benzodiazepine use, as well as polypharmacy, 3) demonstrate how to counsel patients about the risks and benefits of medical cannabis, obtaining cannabis preparations, using a variety of cannabis delivery systems, and state and federal regulations related to its use.

Decoding the Code Status: Can a Palliative Care-Led Curriculum Improve Communications Skills in Critical Care and Emergency Department Clinicians? (FR461A)

Matthew Robinson, MD, University of Texas Health Science Center at San Antonio, San Antonio, TX. Rex Alvin Paulino, MD, University of Texas Health Science Center at San Antonio, San Antonio, TX. Leeling Ong, DO, Kaiser Permanente, Fontana, CA. Jennifer Healy, DO, University of Texas Health Science Center at San Antonio, San Antonio, TX.

Objectives

- Recognize the need for Code Status Discussion training for ICU and ER physicians.
- Consider the role of the HPM-practitioner in leading Code Status Discussion training.

Original Research Background. Communicating effectively with patients/families is an important skill. Palliative care (PC) specialists are often consulted to help with complex communication. In acute settings like the intensive care unit (ICU) and the emergency department (ED) a PC-specialist may not be immediately available, and Code Status Discussions (CSDs) are often required urgently.

Research Objectives. To evaluate the implementation and efficacy of a newly designed CSD curriculum for ED/ICU clinicians.

Methods. ED and ICU medical trainees at a single tertiary care center were asked to participate in the CSD curriculum. CSD curriculum featured the NURSE-SPIKES model of delivering bad news and the PULSES model for CSDs. The 2-hour curriculum included lecture, roleplay/feedback, and handouts. Participants were surveyed before, at 30 and 60 days about their CSD comprehension and communication self-efficacy using Bieber's Questionnaire on the Quality of Physician-Patient Interaction (Cronbach Alpha=0.95). Likert scores were analyzed using Pratt's modified Wilcoxon signed-rank test.

Results. Of 38 medical trainees, N=17 completed the pre-survey. Female=35%; Caucasian=53%, Hispanic=24%, Other=24%; ED=65%, ICU=35%.