

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)



Zachary Sager, MD MA, BIDMC/Boston VA, Boston, MA. Kathleen Faulkner, MD FAAHPM, Good Shepherd Community Care, Newton, MA. Sianna Lieb, MSW, Good Shepherd Community Care, Newton, MA.

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)



Deena Levine, MD, St Jude Children's Research Hospital, Memphis, TN. Robert Macauley, MD MFA FAAHPM, OHSU, Portland, OR. Elisha Waldman, MD FAAHPM, Lurie Children's Hospital of Chicago, Chicago, IL.

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