

- Understand the evidence for dietary supplements in pain management for palliative care and hospice patients.

Pain is a complex multidimensional issue compromised of physical, biochemical, neurological, nutritional, and psychosocial-spiritual components. Primary medical treatments to date habitually treat pain with pharmacologic management as first line of care, yet chronic pain management metrics have not improved. As opioid medications have recently come under intense scrutiny, certain integrative therapies such as acupuncture are now being recognized as effective for many chronic non-malignant pain syndromes, such as chronic headache and chronic low back pain. Palliative and hospice patients often have co-morbid chronic non-malignant pain secondary their palliative diagnosis. Further, as up to half of cancer patients report under-treated pain, an integrative comprehensive pain strategy can provide superior pain management in cancer patients. This presentation will address the evidence and role for integrative therapies, including acupuncture, dietary supplements, mind-body therapies, massage, music, and cannabinoids in the management of chronic and cancer pain.

Vigil Volunteers—The Power of Presence at the Bedside (FR479)



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Objectives

- Outline the key steps in developing a self-sustaining Vigil Volunteer Program from inception to institution-wide roll out.
- Describe a framework to recruit, orient and provide ongoing training for volunteers with little to no experience in caring for patients at the end of life that is both that time and cost efficient.
- List both the benefits and barriers in establishing a model a Vigil Volunteer Program to patients, families and clinical staff.

Many of us have imagined what we want at the end of life (EOL). Most all of us wish to be surrounded by loved ones. Studies show that patients fear abandonment. The reality, however, is that a significant portion of patients die alone. Death creates angst. Dying alone exacerbates this angst.

In our institution, a quaternary care center that routinely accepts patients from hundreds of miles away, a great many patients find themselves alone at the EOL despite having family. The moral distress of dying alone is unimaginable. To address this concern, we developed a Vigil Volunteer program available to

any patient who finds themselves alone at the EOL regardless of whether they had family.

In this session, we will describe the structure and operations of our Vigil Volunteer Program including the iterative process that led to this self-sustaining program. We will use our experience as an example to show how other institutions can develop their own vigil program to suit their individual needs without adding additional staffing.

We will describe the impetus in developing our program, and how we scaled our pilot from a single inpatient unit to the entirety of the institution.

We will discuss the nuts and bolts of the program emphasizing staffing, specifically volunteer recruitment, orientation, and ongoing training and resilience. Finally, we will highlight the benefits to patients, families and health care providers, as well as share the perspective of an actual volunteer's personal experience.

Each member of our team will discuss how our institution has created a therapeutic presence for our hospitalized patients nearing the end of life. We will describe and account for the effect of human, mindful presence positively impacts the care and comfort of those individuals who would otherwise have gone through the journey alone.

The Evolution from Futility to Non-Beneficial Treatment: Updates for the Palliative Care Clinician (FR480)



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Objectives

- Understand the definition and history of the ethical concepts of medical futility and non-beneficial treatment as it pertains to hospice and palliative medicine.
- Discuss the ethical and legal scope and limitations of these concepts in withdrawing/withholding life-sustaining therapies.
- Review the experiences of three hospital systems' implementation of non-beneficial treatment policies, including impact on ethics consults.

Not infrequently, palliative medicine clinicians encounter a patient or family who requests treatment at the end of life that is of little or no clinical benefit. In the majority of instances, these cases can be resolved with thoughtful, value-based communication and shared decision making. However, in some cases, conflict can arise when the patient or family insists on