and the 1970s failed, mainly due to severe toxicity when other opioids were replaced by methadone at excessively high equal analgesic dosages. Our team started to use methadone in carefully selected cases of refractory pain in an inpatient palliative care unit setting. These daily titrations allowed us to learn that while the opiate dose ratio for all other opiate agonists was linear and flat, in the case of methadone the opiate dose ratio became progressively more potent as patients received a higher MEDD of the previous opioid. This knowledge allowed for safer titration and rotation to methadone, resulting in better management of refractory pain.

S1-4 KEYNOTE LECTURE: 'BALANCE AT THE BEDSIDE'—OPTIMIZING BENEFITS AND MINIMIZING RISK THROUGH BEST PRACTICES

Russell Portenoy. *MJHS Institute for Innovation in Palliative Care, USA*

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For those with active cancer, particularly in the advanced phases of illness, opioids are the mainstay treatment for moderate or severe chronic pain. In this context, the potential for benefit when these drugs are used appropriately usually outweighs the risks of side effects, toxicities, and the potential for abuse or addiction. Even in the context of advanced illness, however, clinicians must balance the potential for risk and benefit during opioid therapy, assess risk, and make decisions about drug selection and dosing that minimizes the likelihood of adverse outcomes. Palliative care specialists generally endorse a similar view about pain in populations with other types of advanced illness—opioids are the first-line for chronic moderate or severe pain, but again, risk and benefit must be assessed and techniques used to minimize risk. When cancer or other serious illnesses are not advanced, the potential for adverse opioid effects over longer periods of administration may shift the approach to opioid treatment, emphasizing trials of non-opioid analgesics, concurrent treatments that may reduce opioid requirements, and when opioids are used, greater caution in the selection of drugs and dosing. This approach to risk assessment and techniques to minimize risk applies to all adverse opioid effects, but the most important consideration in the U.S. and some other countries is the risk of abuse and addiction. This lecture begins with a brief discussion of the pharmacological toxicities associated with opioids and an approach to risk management that responds to side effects that are commonly recognized, such as constipation and mental clouding, and those that are less often assessed, such as neuroendocrine effects. The focus then shifts to drug abuse and addiction. The relevant phenomena are described and a stepwise approach is introduced for risk minimization. This approach is appropriately considered whenever opioids are used, including the context of advanced illness. It is a type of universal precautions based on stratifying the risk of abuse and addiction, making informed decision making about opioid selection and dosing, monitoring drug-related outcomes over time, and managing problematic behaviors if they occur.

Symposium 2

Making the case for integration of spiritual issues in palliative care

S2-1 KEYNOTE LECTURE: DEVELOPING EDUCATIONAL AND CLINICAL MODELS IN INTERPROFESSIONAL SPIRITUAL CARE: AN ESSENTIAL COMPONENT OF PALLIATIVE CARE

Christina Puchalski. *George Washington University, USA*

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This session will describe pivotal efforts that have led to models and national and global guidelines for interprofessional spiritual care led by the George Washington University's Institute for Spirituality and Health (GWish). The first is developing innovative curricula in spirituality and health for medical schools in the United States, resulting in National Consensus-based competencies for spirituality and health curricula to better prepare them to provide spiritual care. From this work, an innovative professional development educational program called GWish Reflection Rounds (GRR), was developed as part of professional development of medical students to help them reflect on their relationships with patients and how that impacts their awareness of their own call to serve others who suffer. The second major efforts have been in developing global consensus-based models and guidelines for interprofessional spiritual care. These consensus conferences defined spirituality broadly as a search for meaning, purpose and transcendence, and a connection to the significant or sacred, and provided recommendations for the field of palliative care. These guidelines are based on a generalist-specialist model of care where all clinicians who care for patients with serious and chronic illness are the generalists and the spiritual care professionals are the experts. These guidelines in part contributed to the spiritual domain of the WHA resolution on palliative care and served as the basis of a new initiative called ISPEC—Interprofessional Spiritual Care Education Curriculum, a national and international project to provide spiritual care education to clinicians in partnership with spiritual care professionals. Finally, this session will review current global efforts in collaboration with chaplaincy organizations and health systems to prioritize spiritual care.

S2-2 SUPPORTING THE INTEGRATION OF SPIRITUAL CARE AS AN ESSENTIAL COMPONENT OF PALLIATIVE CARE

Vanessa Battista. *Dana-Farber Cancer Institute, USA*

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Spirituality and spiritual care are important components of high-quality palliative care from the time of diagnosis through the end of life (Zumstein-Shaha, Ferrell, & Economou, 2020). Research has shown that nurses play a key role in helping patients identify their spiritual needs and in responding to those needs. Nurses have found that supporting patients in