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

10.1136/spcare-2023-SCPC.4

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

10.1136/spcare-2023-SCPC.5

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

10.1136/spcare-2023-SCPC.6

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
their spiritual beliefs and helping them find meaning in their illness leads to disease acceptance (Zumstein-Shaha, Ferrell, & Economou, 2020). Thus, it is important for nurses to feel prepared to participate in spiritual care and for spirituality to be integrated into palliative care delivery for all members of the healthcare team.

This session will describe a project that supports the integration of spiritual care as a component of quality palliative care through the lifespan. The project is the End-of-Life Nursing Education Consortium (ELNEC), which is a national and international education initiative to improve palliative care that provides education to nurses, advanced practice nurses, and other professionals in a train-the-trainer model so they can teach this essential information to nursing students, practicing nurses, advanced practice nurses, and other healthcare professionals at their own institutions. ELNEC was started in 2000 and over 1.4 million nurses and other healthcare professionals, representing all 50 US states, plus 101 international countries have completed a national or international ELNEC train-the-trainer course since that time. (www.aacnnursing.org/ELNEC)

Spirituality is a component of the ELNEC curriculum and will be used as an example of how to promote spiritual care as an obligation for all disciplines. This session will highlight the importance of integrating spiritual care as an essential component of palliative care and will provide an example of how a nursing education model includes this type of care.

**S2-3** SPIRITUALITY AND PALLIATIVE CARE: CURRENT EVIDENCE AND FUTURE PRIORITIES?

Karen Steinhauser, Duke University School of Medicine/Durham Veterans Affairs Medical Center, USA

10.1136/spcare-2023-SCPSC.7

Research conducted over the past few decades has made significant strides towards illuminating the role of spirituality during serious illness. We know spirituality is integral to patient and family lives as a framework for meaning-making, coping and decision-making. When spiritual needs are met, quality of life and hospice utilization are higher and costs are lower. However, while the evidence base is growing, in quantity and rigor, the field lacks gold standard approaches to definitions, measurement and assessment. To move forward, we must improve our evidence base with regard to 1) What are the definitions of spirituality and religion, and identifying key domains of those constructs? 2) What is the impact of those domains on key health care outcomes? 3) What are the unique issues associated with research design? 4) How do we best assess spiritual needs and spiritual well-being? And 5) What do we know about interventions to address spiritual and existential care distress and well-being? This paper presents a discussion of our evidence base to date with regard to these key issues. It also offers priorities for improving the evidence base of spirituality and palliative care, so that this key aspect of patient and family experience is more fully understood and met with comprehensive and rigorously approaches to care.

**S2-4** PALLIATIVE CARE THROUGH THE LENS OF SPECIALIST SPIRITUAL CARE

Anne Vandenhoeck. Katholieke Universiteit, Leuven, Belgium

10.1136/spcare-2023-SCPSC.8

Cicely Saunders, the founder of hospice and palliative care noted that caring for spiritual pain was part of palliative care. The search for meaning is a fundamental part of being human. The confrontation with finitude affects the search and experience of meaning and can possibly generate meaninglessness. Nurses, physicians, physiotherapists, social workers, psychologists all need to address what gives meaning in a person’s life and how that expresses itself in values, practices, traditions and belief of their patients. Generalist spiritual care is gaining momentum in research and education. But there is also specialist spiritual care done by spiritual caregivers from diverse traditions. Why are they needed and what is their perspective on palliative care and how do they contribute to the care of palliative patients and their loved ones? In this presentation I will explore specialist spiritual care within palliative care and discuss the evidence, the practice and the outcomes of specialist spiritual care from an international perspective.

**S2-5** EMBRACING A SPIRITUAL AND COMPASSIONATE CARE FOR PATIENTS LIVING WITH ADVANCED AND TERMINAL ILLNESSES WITH EXISTENTIAL AND SPIRITUAL DISTRESS

Marvin Omar Delgado Guay, University of Texas MD Anderson Cancer Center, USA

10.1136/spcare-2023-SCPSC.9

There is an appointed time for everything. A time to give birth and a time to die.

—Ecclesiastes 3:2

What a privilege it is to be able to touch those sacred spaces in the soul of each person in suffering that we encounter every day. Facing our own mortality while suffering a life-threatening illness might create a cascade of distressful physical, emotional, existential/spiritual and social suffering. Patients who express living with existential/spiritual distress might express a loss of the will to live or a loss of the meaning of their lives. They also express low life satisfaction and happiness; worse sleep quality; severe anxiety and depressed mood. At the same time, expressing spiritual struggles might be related to decrease physical functioning and worse survival. Those who express spiritual distress have significantly lower self-perceived religiosity and spiritual quality of life.

With any rupture in the relationships that give us meaning or purpose, no matter the cause of the rupture, our humanity suffers; our soul breaks. It is extremely important for care providers to explore and evaluate that broken soul and try to identify factors from multiple domains that promote healing processes. Embracing the spiritual care into our daily practice is a common effort and a service provided by each member...