availability of palliative care service. We will end this session by discussing the extent of integration of palliative care and oncology in different health systems and areas for future development.

P1-2 INTEGRATING PALLIATIVE CARE ASIDE CURATIVE TREATMENT IN HEMATO-ONCOLOGICAL DISEASE

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Patients with hematologic malignancies face many unmet palliative and supportive care needs. These include, but are not limited to, a sizeable symptom burden, impaired quality of life, significant psychological distress, difficult decisional scenarios, and uncertainty about prognosis. Yet compared to patients with solid tumors, those with hematologic malignances are much less likely to receive specialist palliative care services, despite having similar or greater palliative care needs than those with advanced solid tumors. Patients with hematologic malignancies are also more likely to receive aggressive care at the end of life, including more frequent us of chemotherapy in the last 14 days of life, more frequent hospitalizations and emergency department use in the last month of life, more use of intensive care services in the last month of life, a lower likelihood of using hospice care services at all, and a higher likelihood of dying in the hospital. These markers of poor-quality care at the end of life, coupled with the recognition of unmet palliative and supportive care needs upstream from the end of life in the hematology population, have led to increased interest in efforts to integrate specialist palliative care services into the management of patients with hematologic malignancies. As a dual-trained oncologist and palliative care physician, whose clinical practice focuses on the care of patients with hematologic malignancies, I will focus this lecture on 3 important areas: (1) demonstration of the unmet palliative care needs in hematology patients, (2) description of differences in hematologic diseases that call for a unique approach to integrating palliative care services in this population, and (3) highlighting examples of successful integration in this population, even alongside curative treatment, along with future opportunities to collaborate more closely with hematologists to improve the lives of patients and families who face a blood cancer diagnosis.

P1-3 IMMUNE-RELATED ADVERSE EVENTS ASSOCIATED WITH IMMUNOTHERAPEUTIC AGENTS

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In recent years, immune checkpoint inhibitors (ICPis) have revolutionized treatment of advanced cancers due to their ability to produce durable response in a wide range of tumor types. However, disruption in immune homeostasis due to unbridled T-cell activity produces a unique spectrum of side effects termed as immune-related adverse events (irAEs). These irAEs are diverse and have important clinical implications. Their clinical presentation may vary from mild dermatitis to life-threatening pneumonitis and myocarditis. If not managed promptly and vigorously, irAEs may quickly progress to life threatening and fatal events. In addition, the morbidity associated with irAEs and its impact on quality of life can be sufficiently significant to mandate a dose modification or discontinuation of an otherwise beneficial therapy. With increasing use of immunotherapeutic agents in the treatment of cancer, the incidence of irAEs is on the rise. However, validated markers to delineate patients at risk for developing irAEs are still lacking. Therefore, it is extremely important for physicians to have awareness and a high index of suspicion for early recognition and prompt treatment of irAEs. This presentation will focus on clinical presentation of irAEs and strategies for improving the management of irAEs.

P1-4 CANCER REHABILITATION IN PALLIATIVE CARE

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Cancer rehabilitation and supportive care are two specialties dedicated to improving quality of life in oncology. The two specialties possess services that could potentially benefit advanced cancer patients suffering from significant symptom burden. At MD Anderson Cancer Center, this patient population is often seen by both specialties. This presentation will highlight areas for cooperation between the specialties.

At the crossroads of prognosis, performance status and cancer treatment, cancer rehabilitation specialists often encounter advanced cancer patients when they have suffered a decline in their performance status. Oncology treatment can be withheld until a patient's performance status improves adequately. The effectiveness of rehabilitation interventions in improving function and mobility can impact whether a patient receives additional oncology treatment.

Cancer symptoms can affect performance status and physical functioning. Strong evidence exists that physical activity improves cancer related symptoms including reducing anxiety, depression, and fatigue and increasing quality of life with few side effects and little cost compared to medications. Cancer rehabilitation specialists are experts at exercise and can guide cancer patients through an exercise program while addressing symptoms and minimizing musculoskeletal complications. Furthermore, physiatrists are experts at treating musculoskeletal sources of pain and dysfunction which can assist supportive care physicians in managing pain potentially reducing the need for opiates and their side effects. Besides prescribing physical therapy, physiatrists are able to perform injections (such as joint injections and muscle relaxant injections) and prescribe pain medications. Physiatrists are also experienced in treating other symptoms frequently experienced by cancer patients such as constipation, fatigue and cognitive dysfunction.

Palliative cancer rehabilitation can be incredibly valuable to patients at the end of life. By working with terminal cancer patients and their caregivers, cancer rehabilitation specialists can enable patients with advanced terminal disease to experience meaningful events such as enabling discharge from an inpatient setting to see friends and family members or attend important events such as a wedding or family reunion.

While significant progress has been made, cancer rehabilitation continues to suffer from under-recognition and under-referral by oncologists. These obstacles are similar to those that our counterparts in palliative care have made tremendous recent strides in overcoming. The path for cancer rehabilitation to become standard of care for cancer patients throughout the cancer care continuum including at the end of life will come through proving the efficacy of our interventions through increased research, integrating into clinical practice guidelines, building clinical capacity, and advocating for public policy change. The utilization of costly services at the end of life is often questioned. Research pertaining to palliative cancer rehabilitation interventions have demonstrated improved function and decreased need for caregiver assistance. However, more research regarding cancer rehabilitation interventions at the end of life are urgently needed in particular to demonstrate our impact on cost and clinical outcomes.

Plenary Session 2

Determinants and effects of existential suffering in the clinics of palliative care

P2-1 THE ROLE OF LIAISON PSYCHIATRY FOR EXISTENTIAL QUESTIONS IN PALLIATIVE CARE

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In the palliative care setting, existential issues circulate—implicitly or explicitly, among patients, significant others and clinicians. Different disciplines, such as philosophy, anthropology or theology address existential issues of man. These disciplines may play a role to gain a theoretical perspective, but in the palliative care clinical setting, patients with existential questions or existential distress are often referred to spiritual care and/or liaison psychiatry.

Among the liaison psychiatry approaches, specific interventions based on Existential Psychotherapy (e.g., Meaning-Centered Therapy) co-exist with a growing number of so-called Positive Psychology Interventions. They may be beneficial for patients in existential distress, but also carry certain risks. A risk (i) of psychiatrization of patients' existential experiences, (ii) of focusing on partial aspects of the lived experience of the severely ill and (iii) of neglecting the general psychoanalytic and object relational concepts, which are most helpful to conceive the encounter with patients under existential threat. In addition, they can also shut off from view the role palliative care physicians and nurses have to contain existential distress and obscure liaison psychiatry's task to address clinicians' defensive maneuvers towards the existential in medicine (e.g. by means of supervision).

P2-2 COMMUNICATING WITH PATIENTS EXPERIENCING EXISTENTIAL THREAT

Peter Salmon. *University of Liverpool, UK*

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In Europe and the USA, expectations for how cancer doctors should communicate with patients are shaped by three linked assumptions: (i) Doctors should respect patients' autonomy by providing detailed information and choice around treatment options; (ii) they should support patients by engaging in emotional talk; and (iii) they should learn the communication skills to perform these tasks. Patients and settings vary greatly, and general rules will inevitably not apply universally. Nevertheless, there are now clear theoretical and empirical reasons why these assumptions are the wrong starting points for thinking about cancer doctors' communication with patients. Taking each assumption in turn: (i) Autonomy is a more subtle concept than envisaged in Western ideas of self-determined decisions based on informed choice. More recent ideas of relational autonomy emphasize trusting clinical relationships as the basis of patients' autonomy. Moreover, research indicates that patients often gain their sense of being involved in decisions from being able to trust doctors. (ii) Emotional support is also more complex than envisaged by the view, originating in psychotherapy, that it requires explicit emotional talk. Attachment theory helps to understand how, when people feel vulnerable, emotional comfort arises from trusting someone who provides a sense of safety. Consistent with this theory, research indicates that patients can feel comforted emotionally by doctors' demonstrations of conscientious and expert care rather than by their emotional talk. (iii) The concept of communication skills is too limited to explain 'skilled communication'. That arises when doctors judiciously use their skills, based on their understanding of clinical relationships in general and their unique knowledge of what they and the patient bring to a specific relationship. In many instances, the quality of a doctor's judgment about how to communicate with a patient at a specific moment will be opaque to an observer, who would lack the doctor's clinical knowledge of the case and personal knowledge of the relationship. Therefore, recognizing the importance of doctors' *judgments* in communication means setting aside the emphasis on communication *rules* in western clinical communication education and guidance. Doctors communicate well if they are equipped to make good judgements about what each patient needs, not if they follow pre-established rules.

The challenge for communication researchers and educators is therefore to develop ways to ensure that doctors make good judgments about communication. While there will be a place for adherence to some rules, there will need to be more attention to doctors' character, knowledge and motives, and their ability to reflect on themselves and on their clinical relationships. The literature already contains some pointers to how communication teaching might be approached from this perspective.

P2-3 HOW EXISTENTIALLY DISTRESSED PATIENTS AFFECT CLINICIANS

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Patients' existential distress is a '*pain caused by extinction of the being and the meaning of the self*' (Murata & Morita