

17

DISCUSSIONS ABOUT RESUSCITATION IN ADVANCED ILLNESS: WHAT ARE THE PUBLIC'S VIEWS?

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Background Patients with advanced illness who are at risk of deteriorating and dying are ipso facto at risk of their heart stopping. The law with regards to involvement of patients and relatives in discussions about resuscitation is clear and mirrored in National Guidance. However there is very little evidence about public and user views about such discussions and decisions.

This study aimed to explore the views of public participants with a focus on those from minority ethnic backgrounds.

Method Members of the public were approached through a number of strategies including adverts in hospice shops, local radio, approach to cancer support groups and community organisations. Q methodology was used to reveal key viewpoints and to understand those viewpoints holistically.

Participants attended a workshop where resuscitation was explained together with the likely benefits and harms in advanced illness. Participants then completed a structured ranking (Q sort) of statements about resuscitation to best reflect their views. The 49 statements had been developed with reference to the literature, expert advisors, interviews with professionals and with PPI volunteers. A brief interview was conducted with each participant after their ranking of statements to further explore their views.

Results 38 people with diverse socio-cultural demographics attended 9 workshops. Some participants required one to one verbal translation of materials. Analysis of the Q sorts identified four viewpoints summarised as foregrounding: self-actualisation: ambivalent perspectives; fear of dying; and family as decision makers.

Conclusion Workshops about resuscitation decisions in advanced illness were welcomed. Q method can help describe the public viewpoints about resuscitation and the related discussions and decisions in advanced illness. In turn this information about the way a patient perceives the issues may help professionals best support patients in discussions about their end of life care.

18

A CLINICAL ETHICS COMMITTEE DELIBERATION ON THE HEALTHCARE RESPONSE TO HOSPICE INPATIENTS USING ILLICIT DRUGS FOR SYMPTOM CONTROL

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Background An increasing number of our hospice patients (estimated >10%) are openly using cannabis, mainly for pain relief. A dilemma arises on admission when staff, being patient-focused and bound by confidentiality, feel at odds with organisational convention that prevents illicit drug use on our IPU and could require notification of police.

Methods We canvassed three neighbouring hospices regarding illicit drug use on their inpatient unit (IPU). Our Clinical Ethics Committee (CEC) discussed a patient who in weaning herself off cannabis 'to allow' admission, lost significant analgesia. The CEC considered the acceptability of illicit drugs on

IPUs, documentation issues and the patient/organisational benefits-harms of our approach.

Results The 4 hospices had contrasting levels of tolerance to illicit drugs; one unit had a formal policy. CEC deliberation confirmed inconsistencies and complexities e.g. an array of cannabis-labelled products (kemp/cannabis oil, with varying legality and clinical impact).

The acceptability of 'products' (tobacco to cocaine), context (drug dealer or symptom control) and setting (home or IPU) revealed inconsistencies in acceptability of assisting inpatients (allowing, sourcing, documenting, administering).

Defensive IPU practices underpinned different approaches; plausible deniability (don't tell us), turning a blind eye (typical community approach), or prevent illicit drug use (blanket ban). No-one recommended police involvement. The reputational risk from restricting illicit drug use could do more harm (with societal changes 'ahead' of law).

Conclusion Individualised risk assessments, showing discretion and pragmatism are needed. Holistic approaches to cannabis could justify its use in Palliative Care. Without adequate cannabis substitutes, patients cannot be expected to discontinue cannabis abruptly on admission (whether symptom or recreational use). Cannabis use should be documented, for clinical context/drug interactions. Patient confidentiality would normally hold, unless disclosure was necessitated by a more pressing public interest (greater good). Hospices could agree reasonable parameters with local police to prevent unhelpful responses.

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19

CHALLENGES TO RECOGNISING THE DYING PATIENT IN ACUTE CARE – PERCEPTIONS OF SENIOR AND NEWLY GRADUATED SCOTTISH DOCTORS

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Background Best practice guidelines emphasise timely recognition of dying patients. Continuing futile treatments may reduce the quality of the patient's remaining life. This qualitative study aimed to investigate perceived challenges for doctors in acute specialties when recognising dying.

Methods Semi-structured interviews were carried out with junior (UK Foundation trainees) and senior doctors (consultant in hospital specialties) across South East Scotland. Interviews were recorded, transcribed verbatim and data underwent thematic analysis. Participants have been anonymised through use of pseudonyms.

Results Fifteen junior doctors and thirteen senior doctors have been recruited. All participants described challenges in recognition of dying. Themes emerging from the junior interviews indicate challenges related to perceived dearth of undergraduate preparation; shift patterns leading to poor continuity of care and decision making often only at the point of patient deterioration; uncertainty over level of responsibility for re-evaluating aims of treatment. Senior participants described learning to recognise dying and futility of treatment as having occurred tacitly, and not being explicitly taught. Despite this, seniors described frequent uncertainty in practice, and perceived particular challenges with patients with whom they had long relationships. However, seniors believed that it is the