

Results Of the 1428 stories published on 'Care Opinion' from March 2019 to 2021 regarding hospitals in the West of Scotland, 48 (3.36%) were related to end-of-life care. We found that people tended to post positive feedback about their experiences with end-of-life care. People reported positively about staff professionalism in providing compassionate and person-centered care to meet their loved ones needs at end of life. Nevertheless, other experiences of care related to challenges facing healthcare services, particularly during the COVID-19 pandemic. Quality appraisal of staff responses highlighted areas for improving feedback. Despite research suggesting conversational responses are more desirable by service users, they were the least popular type of responses in our sample and were mostly from negative stories. In contrast, appreciative responses were commonly from families reporting positively about their experiences of end-of-life care.

Conclusion This study has provided a novel perspective of patients' experiences of end-of-life care in hospitals in the West of Scotland. Novel insights were importance of trust and meeting patient's needs at end-of-life particularly by nursing staff.

72 THE IMPORTANCE OF DECISION-MAKING AT END-OF-LIFE: A SYSTEMATIC REVIEW

Tricia O'Connor, Catherine Paterson, Jo Gibson, Karen Strickland, Jo Lewis. *University of Canberra, Bruce, ACT, Australia, Edith Cowan University, Perth, Western Australia, Avondale University, Sydney, Australia*

10.1136/spcare-2023-PCC.92

Introduction Caring for the dying is a multidisciplinary team (MDT) model of care, with nurses providing the most direct patient care. Providing end-of-life care to meet the person-centred needs of individuals and families is complex and relies on effective clinical decision-making (CDM) skills. Little is known about how healthcare professionals (HCPs) inform complex decisions for care intervention when the patient is unresponsive at end of life. The cognitive continuum theory (CCT) has been used to examine CDM in healthcare. This systematic review aimed to critically synthesis empirical links between theory, research, and practice to address the following questions: how has the CCT been used in research, and to what extent has it been integrated in research processes and clinical practice?

Methods A systematic review was undertaken searching five databases from inception. A range of key concepts were mapped to each electronic database. Pre-eligibility screening criteria were applied, and methodological quality appraisal was conducted. A meta-aggregative synthesis was conducted using Joanna Briggs methodology.

Findings Five synthesised findings related to the CDM processes were informed by the CCT. These included: CDM varied depending on the decision-making capacity of the individual HCP, their level of experience, availability of decision tools, access to senior staff and peers, and availability of resources such as time and staffing. The visibility of the CCT was variable, with only two studies rigorously applying the CCT to all stages of the research.

Discussion This review identified a gap in providing a person-centric approach to CDM. This finding was dependent on multifactorial considerations which impacted individual HCPs. Complex DM should be safely embedded in the MDT to sustain the team and improve patient care. Further education and

support is needed, particularly in the context of the unresponsive dying. Impacts of time, resources and workplace culture on CDM need to be addressed.

73 PREDICTING THE FUTURE: WHEN FAMILIES ASK THE 'HOW LONG ...' QUESTION AT END-OF-LIFE

Tricia O' Connor, Wai Man (Raymond) Liu, Juliane Samara. *Clare Holland House, Calvary Health Care, Bruce, ACT Australia, University of Canberra, Australian National University, Canberra*

10.1136/spcare-2023-PCC.93

Background Multiple tools exist to aid prognosis at end of life, yet predicting the length of time to death once the person is unresponsive and deemed to be 'imminently dying' remains fraught with uncertainty. Knowing approximately how many hours or days their dying loved one has left is crucial for both families and clinicians to guide decision making and planning end-of-life care. Previous research has produced useful indicators, but definitive data on length of time from unresponsiveness to death are not reported in the literature. This research sought to determine the length of time between becoming unresponsive and death.

Method A retrospective clinical audit of electronic records of 786 patients receiving specialist palliative care as inpatients, at home, and in aged care homes was conducted across a 10-month period. We analysed the time from the first Karnofsky 10 score to death and used Kaplan-Meier survival analysis to determine the duration of patient's final phase of life, taking into account variation across age, sex, diagnosis, and location of death.

Results From the first time the patient was scored as Karnofsky 10, 49% of patients were unresponsive for longer than one day, with a median duration of 2 days. Regardless of age, the probability of not surviving is identical across all age groups on day two. Having adjusted for age, malignancy, gender, and location, the likelihood of death within 4 days is over 75%. The data also reveals that, regardless of diagnosis, there is a tipping point at around 20–30 days prior to death, from where there is a notable decline.

Conclusion This new data will have a major impact on clinician's confidence when responding to the 'how long' question and can be used to inform decision-making at end-of-life. Findings demonstrate that the Karnofsky 10 score is a highly reliable prognostic indicator.

Poster Nos 74–76: Ethics

74 TEACHING ETHICS WITHIN PALLIATIVE CARE: IDENTIFYING PRIORITY TOPICS AND PREFERRED LEARNING STYLES

Guy Schofield, Harriet Nakiganda, Emer Brangan, Wilson Acuda, Richard Huxtable, Lucy E Selman. *Centre for Ethics in Medicine, University of Bristol; Institute of Hospice and Palliative Care in Africa, Hospice Africa Uganda; All Ireland Institute of Hospice and Palliative Care; Institute of Hospice and Palliative Care in Africa, Hospice Africa Uganda; Centre for Ethics in Medicine, University of Bristol; Population Health Sciences, University of Bristol*

10.1136/spcare-2023-PCC.94

Background There are multiple approaches to teaching clinical ethics in palliative care. What is not clear are the preferences of on-the-ground specialist palliative care providers (SPCPs) regarding which ethics topics to prioritise and the teaching methods to use. Understanding these is crucial in ensuring training programmes and continuing professional development (CPD) are focused, effective, and relevant to time-pressed professionals.

Aim To explore SPCPs' priorities for ethics training topics and preferred methods of teaching delivery

Methods As part of a larger project exploring ethical challenges facing SPCPs in Uganda, we conducted semi-structured interviews with staff in Uganda, exploring their views about priority ethics topics for teaching and preferred teaching methods.

Results 36 participants (17 nurses, 8 physicians, 5 clinical officers, 6 social workers) were interviewed across 7 clinical sites. 11 knowledge areas were prioritised: autonomy, goals of care, confidentiality, nature of ethics and ethical theories, justice, beneficence, truth telling and collusion, non-maleficence, philosophy of palliative care, professional ethics, and euthanasia. Participants also described five skills as important to learn: communication skills; how to approach and manage ethical challenges; self-care for moral distress; understanding one own's ethical biases; and advocacy skills. Five teaching methods were preferred, in order: real-life case group discussion, simulated case group discussion, roleplay, lectures, and clinical placement with an ethical focus.

Conclusion The topics prioritised by SPCPs in Uganda covered a broader range of ethical challenges than is usually included in current training materials. Participants wanted not only ethical knowledge-based training, but also skills training, including self-care related to the moral distress of difficult ethical decision-making. Participants preferred learning via case discussions to lectures or clinical placements. No current comparable data exists for the UK or Irish setting, and these results should be used to spur debate on this subject in these areas.

75 **SHOULD HOSPICES PROVIDE INPATIENT CARE TO PATIENTS VOLUNTARILY STOPPING EATING AND DRINKING WITH INTENT TO HASTEN DEATH? AN ETHICAL ARGUMENT TO SUPPORT PATIENT AUTONOMY WHILST ACKNOWLEDGING PROFESSIONAL DISCOMFORT**

Helen Lock, Cate O'Neill. *Hospiscare, Exeter*

10.1136/spcare-2023-PCC.95

Background Voluntarily stopping eating and drinking (VSED) with intent to hasten death, even in the context of concurrent disease, can be argued to constitute a form of suicide, albeit by omission rather than act. In the UK, therefore, where assisted suicide is not legally permissible, providing inpatient nursing and medical care to a patient competently withholding food and fluid intake with the aim of ending their life potentially raises legal and ethical challenges.

Argument We argue, however, that healthcare professionals are ethically bound to uphold patient autonomy, and an informed, capacitous decision to voluntarily stop eating and drinking represents autonomous patient choice. Furthermore, to force enteral or parenteral fluids or nutrition on a capacitous patient would constitute battery. Assuming patient capacity is

maintained, and the provision of basic care including the offer of food and fluids continues, providing care to patients voluntarily stopping oral intake is legally unproblematic. Ethically it is not necessary for healthcare professionals to share the patient's intention of hastening their death to provide clinical care, hence they should not be considered complicit or instrumental to a patient's deterioration through VSED.

Inpatient care may be necessary for patients voluntarily stopping eating and drinking to ensure optimal physical and psychological symptom management towards end of life, with hospices being ideally placed to meet these needs. Declining to admit such patients to a hospice on the basis that this may constitute assisting suicide risks leaving them vulnerable to suboptimal symptom control and merely displaces ethical discomfort onto an alternative group of healthcare professionals.

Conclusion Hospices should be open to providing inpatient care to patients voluntarily stopping eating and drinking, confident in the ethical clarity that they are supporting patient autonomy, but acknowledging the moral burden for involved healthcare professionals who may not share a sentiment to hasten death.

76 **SEDATION OR ASSISTED DYING? – AN ETHICAL ARGUMENT**

Till Kroeber. *Strathcarron Hospice*

10.1136/spcare-2023-PCC.96

Introduction Palliative care facing the unbearable, sustained suffering of some terminally ill patients seeks ways to relieve this suffering, while staying within professional ethical boundaries that can change over time. Given that the proposed Assisted Dying for the Terminally Ill Adults (Scotland) Bill is currently going through the Scottish Parliament, it is worth comparing forms of terminal sedation to assisted dying from an ethical perspective.

Argument A procedure that causes less harm while achieving the same benefit is preferable to a treatment that causes greater harm. Certain forms of sedation do not terminate life. Assisted dying terminates life, which can be seen as the ultimate harm.

Both achieve an end to suffering for the patient. Therefore, certain forms of sedation are preferable to assisted dying.

Details Life can be said to have an intrinsic value, and to avoid doing harm is an established ethical principle. Forms of sedation that do not terminate life are late deep continuous sedation, intermittent deep sedation, and proportionate palliative sedation. Only the latter is widely practiced in the UK. Sedation can be said to cause the lesser harm of unconsciousness, compared to the greater harm of death. However, too light sedation is insufficient to relieve suffering whilst too heavy sedation can contribute to the termination of life. To terminate life through assisted dying can be seen as the ultimate violation of the ethical principle to do no harm. Both assisted dying and forms of sedation can be said to relieve subjectively experienced, unbearable suffering.

Conclusion Late deep continuous sedation, intermittent deep sedation, and proportionate palliative sedation respect the intrinsic value of life, thereby avoiding the main ethical objection to assisted dying. It is important to explore, in detail, the role and practicalities of various sedations for palliative patients.