

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.

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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

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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.

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SEDATION OR ASSISTED DYING? – AN ETHICAL ARGUMENT

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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.