

supported with blood transfusions every other day, to pace with family members to come to acceptance. Eventually they were agreeable with the medical recommendation to discontinue further blood transfusions and he was discharged back home with home hospice support.

Discussion This case raises the ethical dilemma of blood transfusions despite medical futility, while balancing the family's maintenance of hope. The Jonsen's Four Box Method (figure 1)¹ enables physicians to navigate a holistic approach.

In Mr W's case, it was recommended that repeated blood transfusions be withheld. There were no alternative curative interventions for his active bleeding that could be taken upon safely, and the low chances of a spontaneous recovery weighed significantly less against the increasing harm of worsening fluid overload. He remained comfortable and symptom-derived benefits from transfusions were negligible; fatigue and reduced activity are nonspecific symptoms and are often considered insufficient reasons for transfusion. In addition, the presence of his life-limiting metastatic CRPC, ongoing functional decline, and infective complications already portends a poor prognosis. Further prolongation of hospitalisation with repeated intravenous cannulation was not in keeping with quality of life to him. Offering a trial of therapy, with clearly defined end-points, to demonstrate medical futility facilitates acceptance of the circumstance and aligns eventual goals of care. It is imperative that physicians provide families with accurate, current, and frequent prognostic estimates throughout the course of the illness. There is a need to address the emotional needs of the family to understand the problems from the family's perspective by being available, approachable, and compassionate.

REFERENCE

1. Albert R Jonsen, Mark Siegler, William J Winslade. Clinical ethics a practical approach to ethical decisions in clinical medicine.

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END-OF-LIFE CARE QUALITY FOR VULNERABLE POPULATIONS IN AUSTRALIA: THE COMMUNITY PERSPECTIVE

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Background Vulnerable populations are highlighted across Australian national palliative care (PC) and end-of-life care (EOLC) documents to increase care equity and inclusivity; however, there are disparities in listed populations across these documents, and justification of inclusion is limited. This narrative review aims to describe current literature about the EOLC experiences of the vulnerable populations listed across these care-influencing documents from the community perspective (comprising the perspectives of decedents, family members and caregivers).

Methods Separate literature searches were conducted for the fifteen vulnerable populations identified across three key national EOLC documents (Palliative Care Standards 2018, the Australian Government Department of Health's 'Exploratory Analysis of Barriers to Palliative Care' and the National Consensus Statement on 'Essential Elements for Safe and High-Quality End-of-Life Care'). Eight vulnerable populations were included for discussion as their searches returned one or more relevant articles. As the literature was almost entirely descriptive, a concept-based approach was used to describe the

EOLC experiences of included populations. Concepts were synthesised from key and recurring topics throughout the literature.

Results Agency and communication were critical areas for improvement amongst all included vulnerable populations. Concepts identified for the eight vulnerable groups included were as follows: for people living in rural and remote settings, concepts included EOLC designed for metropolitan settings, limitations of local services and interventions in rural communities; for people with dementia concepts included comfort of people with dementia, carer experiences and access to PC; for people with culturally and linguistically diverse backgrounds concepts included culture and decision-making, balancing death taboo and advance care planning discussions and trust in the healthcare system; for people living in residential aged care facilities (RACFs) concepts included advanced care planning in RACFs, place of death preference vs reality and inclusivity of RACFs; for Aboriginal and Torres Strait Islander Peoples concepts included fear of relocation to receive EOLC, culturally competent communication and resources and access to services in the community; for people who identify as lesbian, gay, bisexual or transgender (LGBT) concepts included expressing sexuality and gender identity, social isolation of people who identify as LGBT and substitute decision-makers and legal rights for people who identify as LGBT; for people living with disabilities concepts included access to disability-inclusive services, discrimination by healthcare professionals and disability support workforce and family limitations; for people experiencing incarceration concepts included balancing risk vs humanity and entitlements and inaccessible agency.

Implications Although enablers were identified throughout the literature, there was a predominant focus on barriers and negative experiences, perhaps speaking to the cumulative narrative for vulnerable populations. Evidence describing the experiences of the community was limited, with many studies conducted over twenty years ago, which illustrates a significant literature gap. Further research describing community experiences of EOLC across a broader range of settings for all identified populations is needed to inform future EOLC initiatives and standards and may assist in determining an accepted set of vulnerable populations across guidelines.

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QUALITATIVE EXPLORATION OF GYNAECOLOGY ONCOLOGISTS' VIEWS AND UNDERSTANDING OF PALLIATIVE CARE

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Background Patients with advanced gynaecological cancers have high symptom burden and supportive care needs and have traditionally had little and delayed involvement with specialist palliative care.

Aim This qualitative study explores the views and experiences of consultant gynaecological-oncologists and their trainees in managing advanced gynaecological cancers, providing generalist palliative care (with a specific focus on symptom profile and end of life care), as well as reflecting on their interactions with palliative care services in an Australian healthcare setting.

Methodology All gynaecological-oncology specialists and fellows working and training in the state of Victoria, Australia