significant physical and emotional demands of palliative care. Consequently, hospices employ a range of strategies to support and develop their staff, but it is not clear which are the most helpful, the best value or whether certain combinations are needed. Though ethical considerations are a prominent and common source of distress for hospice staff, clinical ethics rarely receives as explicit or frequent attention within hospices when compared to other support structures.

Methods We critically reviewed the staff support and development structures at a large hospice in southeast England, spanning: informal colleague support, reflective practice sessions, teaching, line management and specific additional support such as clinical supervision, Clinical Ethics Committee (CEC) and Schwartz Rounds.

Results Our review identified, then compared and contrasted, the key mechanisms of staff support and development: — CEC (what is the ‘right thing’ to do) — Reflective Practice (how to best go about doing the ‘right thing’) — Clinical Supervision (being personally able to do the ‘right thing’) — Schwartz Rounds (how doing the ‘right thing’ feels).

Conclusion Appropriate staff support and development is vital for hospices to deliver high quality, sensitive and individualised patient care. Four mechanisms appeared pivotal in their ability to provide all four of these cornerstones, including the often neglected clinical ethics.

REFERENCES

97 REVIEW OF DATA FROM THE 2016 OFFICIAL REPORTS OF THE DUTCH TERMINATION OF LIFE ON REQUEST AND ASSISTED SUICIDE ACT AND OREGONS DEATH WITH DIGNITY ACT

Baroness Ilora Finlay. House of Lords

Of 6091 notified cases of physician assisted suicide (PAS)/euthanasia (PAE) in the Netherlands, 3840 (63%) were 70 years or over: the proportion rises to 86% (5248 PAS/PAE deaths) if over-60s are included.

Oregon’s official report on their PAS law, which requires a diagnosis of <6 months, shows 71% of PAS deaths in 2016 were aged 65 or over (median 73 years).

Both legislatures show rising incidences of PAS/PAE since legislation came into force. In the Netherlands the annual numbers of deaths initially remained stable and fears of rising death rates were thought groundless. After 2007, the annual numbers of deaths began to rise steeply. In 2016, 1 in every 25 deaths the result of legalised PAS or PAE. A law like Holland’s 2001 Act would probably result in around 21 000 such deaths annually in England and Wales.

In 2010, of 3,136 Dutch PAS/PAE notified, 2781 (89%) were related to cancer, cardiovascular and neurological disorders and 11 per cent to other conditions. By 2016 a rising proportion (17%) related to multiple geriatric syndromes, dementia (n=141), psychiatric disorders (n=60), and other conditions. Statistics Netherlands data confirms this trend.

Extension of euthanasia caused psychiatrist Boudewijn Chopot, whose prosecution preceded Dutch legislation, to express concern, writing that the foundation of the law has been gradually eroded so that now it ‘does not provide protection to people with dementia and psychiatric problems.

Non-assisted suicide rates have not fallen where PAS/PAE is legalised, but the introduction of PAS seemingly induces more self-inflicted deaths than it inhibits. WHO data shows higher-than-average suicide rates per 1 00 000 population (2015) of 20.5 in Belgium, 15.1 in Switzerland, 12.3 in Canada, 11.9 in