

## 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

consultant responsibility to diagnose dying and/or withdraw treatments. Both juniors and seniors described being less inclined to diagnose dying if the patient is young and/or has young children.

**Conclusions** This study has revealed challenges in recognition of dying perceived by Scottish doctors. The findings suggest this area of patient care is complex and uncertain, even for experienced practitioners. Comparing perceptions of senior and junior doctors gives insights for potential means of improved medical education. Recommendations include clearly defining the responsibilities of junior and senior team members, being explicit with learners about the often uncertain nature of recognising dying, and improved organisational factors to facilitate continuity of care.

## 20 NEGATIVE PERSONAL EMOTIONAL IMPACT OF CARING FOR THE DYING – EXPECTATIONS OF FUTURE DOCTORS. A MULTICENTRE STUDY

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**Background** End of life care (EOLC) is a large part of junior doctors' workload. Negative attitudes may impact on care provided and may be shaped during undergraduate medical training.

**Aims** We investigated:

- whether medical students expect EOLC to have a negative emotional impact on themselves
- demographic and psychological factors associated with such expectations.

**Methods** Multicentre cross-sectional online study of 1520 first and 954 final year medical students from 18 universities, (16 UK, 1 New Zealand, 1 Ireland). We assessed attitudes towards EOLC (Sullivan's statements), age, gender, course year, course type (standard or graduate), spirituality and experience of bereavement as well as psychological variables: death anxiety (Collett Lester Fear of Death Scale, COLFD), empathy (Davis's Interpersonal Reactivity Index, IRI) and depression (Hospital Depression Scale HADS-D). Factor analysis suggested 3 Sullivan statements formed a 'negative personal emotional impact score' (Impact Score, -6 to +6). Students with low/neutral (-6 to +3) and high (+3 to +6) Impact Score were compared (Ī<sup>2</sup>-tests and ANOVA) and regression analyses undertaken.

**Results** Respondents were neutral overall (mean Impact Score=0.3), although with substantial variations. Participants with high Impact Score were likely to be younger, standard course, first-year students, and to have higher depression and distress scores (HADS-D and IRI-Personal-Distress-scale), lower cognitive empathy scores (IRI-Perspective-Taking) and to score more highly on all COLFD sub-scales. Regression analysis showed psychological factors were strongly associated with the Impact Score: COLFD others-dying (1.29;CI: 1.08 to 1.50; p=0.001), IRI-Personal-Distress-scale (0.97;CI: 0.77 to 1.17; p=0.001), HADS-D (0.45;CI: 0.17 to 0.74;p=0.002), and

COLFD others-death (0.31;CI: 0.09 to 0.54;p=0.006) scales were the strongest predictors.

**Conclusions** Medical students worry about the possible negative personal emotional impact of EOLC when doctors. While medical education may mitigate such concerns, negative expectations appear related to distress, death anxiety and depression. Measures to improve and support psychological well-being may have a positive impact on medical students' attitudes toward EOLC.

## 21 REAL TALK – A NOVEL EVIDENCE-BASED, VIDEO-BASED COMMUNICATION SKILLS TRAINING RESOURCE

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**Background** Much palliative care communication training draws on sparse evidence about practice. Yet training's effectiveness depends on the strength of its underpinning evidence. An empirical, observational science of language and social interaction – 'Conversation Analysis' holds great promise because:

- it is generating copious evidence on communication, and healthcare-communication specifically;
- shows role-played interactions differ from authentic ones in fundamentally important ways;
- recent quantitative evaluations of interventions based on conversation analytic findings have shown effectiveness.

Within a research and training development programme, we designed novel training resources – 'Real Talk' incorporating research findings and clips from video-recorded hospice consultations. We designed Real Talk to complement rather than replace existing resources. We report a preliminary evaluation of Real Talk's strengths and weaknesses.

**Method** Mixed-methods, qualitative evaluation entailing observations, interviews, and participant-completed feedback questionnaires.

**Results** We collected data from 11 events, 10 trainers across England, and 150 trainees.

**Conclusions** Trainees and trainers alike appreciated the video clips and their authentic nature. Observations and reports indicated Real Talk was particularly effective for encouraging participants to both emotionally engage with the nature of palliative care, and actively engage in discussion and overall learning about communication practices. Trainers used the video clips more than they did the research findings components; with a similar pattern seen in most trainees' feedback. Our decision to design Real Talk for trainers to use without initial intensive training meant we could rapidly and widely distribute the resources and evaluate their use. However, this also meant heavy reliance on trainers' existing facilitation skills, and on their allocation of adequate time to familiarise themselves with the materials. We argue that this is also why the research findings-based components were not put to full use by trainers. We are revising Real Talk and its delivery on the basis of our evaluation.