Conclusion Despite numerous campaigns to improve patient involvement many still do not participate in their own safety. Patients without tertiary education, patients over 60, and those who are not fluent in English are much less willing to challenge healthcare professionals about safety-related issues. Understanding the impact of patient demographics on participation in safety behaviours could help to create novel, more targeted strategies to improve patient safety. This could effectively reduce preventable medical errors in palliative care medicine where patients are more vulnerable to such errors.

69 EMPIRICAL ETHICS AND PALLIATIVE CARE: A SYSTEMATIC REVIEW OF THE ETHICAL CHALLENGES IDENTIFIED BY SPECIALIST PALLIATIVE CARE PRACTITIONERS IN THEIR DAY-TO-DAY CLINICAL PRACTICE

Guy Schofield, Mariana Dittborn, Richard Huxtable, Emer Brangan, Lucy Selman. *Univeristy of Bristol, King's College London, University of Bristol, The National Institute for Health Research Collaboration for Leadership in Applied Health Research and Care West (NIHR CLAHRC West) at University Hospitals Bristol NHS Foundation Trust*

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Background Ethical issues arise daily in the delivery of palliative care. Despite much (largely theoretical) literature on the ethics of palliative care, evidence from specialist palliative care practitioners (SPCPs) about the day-to-day ethical challenges they encounter has not previously been synthesised. This evidence is crucial to inform education and training, and support staff.

Aim To synthesise the evidence regarding the ethical challenges which SPCPs of all professional backgrounds encounter during clinical practice.

Methods A prospectively registered systematic literature review using narrative synthesis methodology (Popay et al 2006) was conducted. Key words and subject headings of 8 databases (MEDLINE, Philosopher's Index, EMBASE, PsycINFO, LILACS, WHOLIS, Web of Science and CINAHL) were searched on 03/10/2018, without time limits. Eligible papers reported original research using inductive methods to describe SPCP-reported ethical challenges, in any language. Quality was dual assessed using the Mixed-Methods Appraisal Tool. Tabulation, textural description, concept mapping and thematic analysis were used to develop and present the narrative.

Results 7040 records were screened. 12 studies from 9 countries were included. All included studies examined adult care. A broad range of ethical challenges were identified in 5 themes: patient-related (e.g. autonomy, truth-telling), patient-family relationship (e.g. boundaries of confidentiality, family-patient conflict), clinical issues (e.g. futility, palliative sedation), organisational factors (e.g. value differences between professions and care settings, place of care), and wider system (e.g. euthanasia, organ donation).

Conclusion SPCPs encounter a broad range of ethical challenges, not all of which are recognised in the ethics literature or form part of training curricula. In particular, the challenges of differing value positions between hospice and curative sectors and genetics ethics seldom occur in theoretical discussions of palliative care ethics or training, while withdrawal of life-prolonging treatment and euthanasia are more commonly represented. Findings of the review can inform SPCP ethics education, training and support.

70 SYSTEMATIC REVIEW ON THE DOCTRINE OF DOUBLE EFFECT WITHIN PALLIATIVE CARE

Craig Gannon. *Princess Alice Hospice, Esher, Surrey, UK*

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Background The Doctrine of Double Effect (DDE) suggests pursuing a morally good action, despite foreseeable bad side-effects (including death) is still ethical, providing the bad side-effects weren't intended (within set circumstances). Consequently, DDE is a means of freeing doctors to prescribe morphine for pain at the end-of-life without misplaced legal fears. However, increasingly the role for DDE in Palliative Care is being questioned.

Our aim was to collate the current arguments for and against a role for DDE in Palliative Care, to provide an updated position.

Methods A systematic literature review was performed on DDE in Palliative Care. Peer-reviewed publications included if; English; abstract (to confirm applicability); from last 5 years (2013–2018). 10 full papers were analysed and key arguments summarised. This qualitative data was combined, addressing the research question.

Results Persuasive support both for and against DDE in Palliative Care was identified.

Positives; legal prerequisite (realising treatment morbidity/mortality); important moral 'tool' (doctors require 'good intentions'); and expert clinical support (championing DDE).

Negatives; unnecessary (no legal/clinical need); not applicable (distancing by palliative care); misinforms (fuels misplaced opioid fears); paternalistic (about staff, not patient-centred); unusable (complex, and intent/motive untestable); risks diversion from tailored dosing (poor practice, even if well-meaning); not a blanket 'doctrine' (or an 'untouchable' defence if misprescribe opioids).

Discussion The literature remains divided on current importance of DDE. DDE has inherent philosophical value with historical impact and current support. However, DDE's applicability in Palliative Care is unclear (because appropriate symptom control doesn't cause death); inconsistencies refute the presumed need (DDE is not needed to 'protect' prescribers in chemotherapy-related neutropenic sepsis deaths); and DDE allows potential harm (unintentionally providing a medical defence if deliberately administer a fatal opioid overdose)… sufficient to undermine DDE's current value. 'Best practice' appears a better tenet to guide doctors.

71 LEAVING AN IMPLANTABLE CARDIOVERTER DEFIBRILLATOR ACTIVE AT END OF LIFE – BALANCING CURRENT AND POTENTIAL FUTURE HARMS

Rosie Bronnert. *University Hospitals of Leicester*

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The number of people with implantable cardioverter defibrillators (ICDs) has increased. Consequently more people approaching the end of their life have an ICD *in situ*.

Sensitive and timely conversations enable a planned ICD deactivation to take place in the majority of people approaching the end of their life. However, in a small number of cases, our multi-professional team have not been able to reach