Clinical case 83 years-old-man with a gastric cancer state IV. Married with a woman with Dementia who is waiting for a long stay public residence. No children. No cognitive damage. Fatal prognosis with a need of permanent enteral nutrition, which, he doesn't want to use and clinicians strongly recommends. Great anxiety and suffering. Decision making capacity. Wish to die.

Discussion Patients with the capacity to make medical decisions can refuse medical care even if this refusal results in their death. Sometimes, a "comfort measures only" can be a better option than trying to keep life. Old people with no family are often less informed and taken in count in making decisions. A symptom management, good patient-clinicians communication, psychosocial, spiritual, and practical support and respecting patient's wishes and decisions is a main goal in any medical care.

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EV0546

Defensive psychiatry. An ethical perspective

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Introduction The legal dispute between doctors and patients is increasing. The "frivolous lawsuit" is spreading and the psychiatrist is being dragged to court in the dock. Guidelines and operational protocols become the bastions of the defensive psychiatry. Defensive psychiatry involves, for example, a larger number of hospitalizations, also involuntary admissions, and psycopharmacological prescriptions.

Objectives We want to see if the issue of defensive psychiatry is perceived by psychiatrists as a risk in their clinical practices and what consequences may result in the relationship with the patient.

Methods Through an audit and through a literature review get to define the defensive psychiatry.

Conclusions Though there is much confusions and uncertainty in this field, the defensive psychiatry distorts the relationship with the patients and proposes the questions of social control.

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Whose insight is it anyway?

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Introduction There is little research comparing patients' views with those of their treating psychiatrists. In a survey of patients' views conducted in 1993 for MIND (UK) by Rogers, Pilgrim and Lacey only 10% saw their problems in terms of mental illness. This highlights the tension between psychiatric codifications of mental abnormalities and explanations provided by patients themselves.

Aims This pilot project explores the perceptions of mental health issues in patients and their psychiatrists in a regional Western Australian setting.

Methods A mixed methods approach including semi-structured interviews of patients and their treating psychiatrists. Recruiting 5 consecutive people in the categories of involuntary in-patients, voluntary in-patients, patients on CTO, community patients and their psychiatrists.

Questions asked of the patients were:
– Why are you here?
– What problems do you have?
– What can be done?
– What control do you have?
– What control do other people have?

Psychiatrists were asked similar questions. Responses were recorded, transcribed and thematically analyzed to reveal key themes. Quotations are used to illustrate points participants wished to make.

Results We report on differences in understanding in both groups. This study reveals areas for further enquiry.

Conclusions Considerable diversity is revealed. A key conclusion is that insight is a concept relevant both for treated and treating.

Disclosure of interest The authors have not supplied their declaration of competing interest.

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