

The GMC and End of Life Care – a position paper

June 2007

Regulating doctors
Ensuring good medical practice

Background

1. The General Medical Council (GMC) licenses doctors to practise medicine in the UK under the provisions of the Medical Act 1983 (as amended).
2. Our objective, as defined in the Medical Act, is to "protect, promote and maintain the health and safety of the public". Our four main functions are:
 - a. to keep up-to-date registers of qualified doctors;
 - b. to foster good medical practice;
 - c. to promote high standards of medical education; and
 - d. to deal firmly and fairly with doctors whose fitness to practise is in doubt.
3. Our governing body, the Council, is made up of both medical and lay members.

The GMC's interest in End of Life Care

4. The GMC supports the Government's aim of ensuring that patients nearing the end of their lives have access to high quality palliative care, both in hospital and community settings, regardless of their diagnosis. And we agree that access to these services should be provided equitably to all groups in society.
5. There are a number of ways in which the work of the GMC can contribute towards these goals, through our role in medical education and training and our guidance on good practice.

Raising awareness and increasing skills amongst healthcare staff

Undergraduate education

Developing the curriculum

6. The GMC is responsible for setting the standards and outcomes for undergraduate medical education in the UK. These are described in our publication *Tomorrow's Doctors* (2003) which outlines the requirements for curricular content, structure and delivery and sets out the knowledge, skills, attitudes and behaviours expected of medical graduates in order to gain entry to the profession.
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7. There are a number of areas within Tomorrow's Doctors which are relevant to raising awareness about and developing competences in providing end of life care. We would draw attention, in particular, to paragraph 16 which provides that:

“Graduates must know about and understand the principles of treatment including the following...

b. How to take account of patients' own views and beliefs when suggesting treatment options.

c. The effective and safe use of medicines as a basis for prescribing....

h. Relieving pain and distress.

i. Palliative care, including care of the terminally ill.”

8. We started work to scope a review of Tomorrow's Doctors in 2006. Consultation on an initial working paper (http://www.gmc-uk.org/education/education_consultation/index.asp) provided useful feedback on a number of areas. However there was little specific comment on palliative care issues. The full review is getting underway and we plan to publish a draft new edition of Tomorrow's Doctors for consultation early in 2008. We are willing to consider further suggestions on the revised content ahead of the consultation. However it's important to remember that, given the number of areas of practice which are priorities for NHS service improvement, difficult judgements will have to be made about the extent to which we can make specific provision within the undergraduate (or postgraduate) curriculum. And of course, Tomorrow's Doctors is a high level framework with much of the detail of medical curricula being left to the medical schools themselves to determine.

Quality assuring the medical schools

9. We do not prescribe how medical schools should develop their undergraduate programmes to deliver the requirements in Tomorrow's Doctors. There is great diversity in the detail of UK undergraduate programmes, and we can speculate this will also be true of curriculum content relating to end of life care.

10. Our quality assurance visits provide opportunities to identify examples of good practice in achieving the required learning outcomes, and to disseminate these more widely amongst the medical schools. We can consider whether scope exists to target areas of special interest such as palliative care. But this will also depend on other pressures on the quality assurance process.

Postgraduate education and training – the new doctor

The curriculum for the Foundation Programme

11. After graduation there is a 2 year training period – the Foundation Programme¹ – during which doctors prepare for full registration with the GMC (on

¹ The Foundation Programme was established in 2005 following major reviews of postgraduate training by the GMC, and by the UK Health Departments under their Modernising Medical Careers (MMC) initiative. The

completion of F1), and for entry to specialty training programmes (on completion of F2). The GMC is responsible for setting the educational requirements for F1 and the Postgraduate Medical Education and Training Board (PMETB) is responsible for F2.

12. The standards that Postgraduate Deaneries delivering the Foundation Programme must meet, and the outcomes that doctors must demonstrate at the end of F1 in order to be eligible for full registration, are set out in *The New Doctor* (2007), http://www.gmc-uk.org/education/foundation/new_doctor.asp. These standards and outcomes are incorporated in the Curriculum Framework for the Foundation Programme - the national curriculum developed by the Academy of Medical Royal Colleges (AoMRC) and Modernising Medical Careers (MMC), see <http://www.mmc.nhs.uk/pages/foundation/Curriculum>.

13. The Curriculum syllabus and competences (in section 4 of the framework document) describes areas of knowledge, skills, attitudes and behaviours which can contribute to improved standards of care towards the end of a patient's life. These include, for example:

Part 1.3(i): the patient as the centre of care

Part 1.3(iii): good team working for patient safety

Part 1.6: nutritional care

Part 4: relationships with patients and communication skills

Part 5: communication with colleagues and teamwork

Part 7: core skills in relation to acute illness; especially 7(xiii), 7.2, 7.4 and 7.5

A great deal of part 7 is relevant to end of life situations. However, the syllabus contains little direct reference to 'end of life' care:

Part 1.1(iv) An F1 doctor, 'understands and applies the principles of therapeutics in palliative care'.

14. The strong focus on managing acutely ill patients, including acute presentations of chronic disease (part 7), reflects the priority that was attached to this area of practice by MMC and by those who responded to consultations on the draft curriculum. It should be possible to consider giving more prominence to other areas of practice when the curriculum is updated. The curriculum is being kept under review by AoMRC who plan to revise it in 2009. It's worth noting that PMETB have launched a consultation on the content and outcomes of postgraduate education which provides a more immediate opportunity to flag up concerns about addressing end of life care issues.

Quality assuring the Foundation Programme

programme was implemented on a transitional basis from August 2005 and comes fully into effect from August 2007.

15. Our joint GMC / PMETB process for quality assurance of the Foundation Programme (QAFP) provides a mechanism to ensure that the curriculum and required outcomes are being delivered. It also provides a means of identifying notable practice. Here too, we can consider whether there might be scope to target end of life care.

Standards for Practising Doctors

16. To support doctors in their day to day professional practice, as well as the core guidance in *Good Medical Practice*, we publish advice on a range of issues which are seen as central to delivering high standards of patient care.

17. A great deal of the advice in *Withholding and Withdrawing Life-Prolonging Treatments (2002)* and some key aspects of *Good Medical Practice (2006)*, will be relevant to ensuring that doctors practise in a way that supports patients' access to good quality end of life care. For example In *Good Medical Practice (GMP)* we highlight doctors' responsibility to:

“take steps to alleviate pain and distress whether or not a cure may be possible.” GMP paragraph 3(b).

“..be considerate to relatives, carers, partners and others close to the patient, and be sensitive in providing information and support, including after a patient has died.” GMP paragraph 29.

More specifically, in our booklet *Withholding and Withdrawing Life-Prolonging Treatments*, we emphasise the need to give early consideration to the possible palliative care needs of patients [see Annex A]. We also provide advice on good practice in making decisions about CPR and ANH, at paragraphs 78-94 of the booklet.

18. We plan to start work on updating the guidance in *Withholding and Withdrawing Life-Prolonging Treatments* in Summer 2007. This review will provide a further opportunity to promote key messages about doctors' roles in providing good quality end of life care.

Continuing Professional Development

19. When doctors cease formal training the GMC requires them to keep their knowledge and skills up to date throughout their working lives, including taking part in educational activities that help to maintain and develop their competence and performance. However the GMC has no formal role in setting requirements for educational programmes to support continuing professional development (CPD).

20. We have collaborated with key organisations involved in providing and accrediting CPD programmes, to produce guidance on the principles which should underpin the design and delivery of such programmes, see http://www.gmc-uk.org/education/pro_development/pro_development_guidance.asp. However we are not in a position to know to what extent current CPD provision around end of life

care issues might be sufficient (in terms of availability or quality) to meet the needs of practitioners working outside specialist palliative care.

21. We have some evidence from work undertaken in 2006 which suggests that more should be done. In the Summer, with support from a number of Postgraduate Deaneries, we ran 13 educational events for clinicians (multi-professional audiences), to discuss the content and application of our guidance on *Withholding and Withdrawing Life-Prolonging Treatments*. In total 900 clinicians attended (and most events were oversubscribed). This suggested significant unmet demand for education and training resources, outside of specialist palliative care teams/settings, from clinicians and patient support workers who want to improve their practice around end of life care.

22. The GMC is not in a position to lead in developing CPD programmes, but we are willing to consider supporting initiatives to encourage the development of CPD resources for end of life care.

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ANNEX

Extract from: Withholding and Withdrawing Life-Prolonging Treatments: Good Practice in Decision-making

Care for the dying

26. Patients who are dying should be afforded the same respect and standard of care as all other patients. Patients and their families and others close to them should be treated with understanding and compassion. Where the likely progression of a patient's condition is known, and their death is seen as an inevitable outcome, it is important to ensure that the patient's palliative care or terminal care needs are identified and met appropriately. This should include consideration of their wishes regarding such matters as the appropriate place for receiving care (which may affect the treatment options available), and their needs for religious, spiritual or other personal support. Every attempt should be made to ensure that they are afforded privacy, dignity, and good quality care in comfortable surroundings. This includes assessment of, and adequate relief from, pain and other distressing symptoms, and appropriate support and nursing care.

27. Discussion about the dying process allows patients the opportunity they may want to decide what arrangements should be made to manage the final stages of their illness, and to attend to personal and other concerns that they consider important towards the end of their life¹¹.

Seeking the patient's views

43. Where the possibility of withholding or withdrawing a life-prolonging treatment is an option, you should offer the patient the opportunity to discuss how their care would be managed if such a decision were made. This should include:

- arrangements for providing nursing care and other appropriate treatments;
- the patient's preferences about who should be involved in decision making or in providing additional support if they become incapacitated;
- what might be their palliative or terminal care needs should death become inevitable and how these would be met¹².

Discussions of this sort, handled sensitively, may help to build trust and provide an opportunity for you to get information about the patient's values and priorities that might be helpful in later decision making.

¹¹ For advice on issues which patients may want to explore consult publications like 'The Future of Health and Care of Older People', Age Concern. 2000. 'Feeling Better: Psychosocial Care in Specialist Palliative Care'. National Council for Hospices and Specialist Palliative Care Services, August 1997.

¹² For further advice on management and aftercare issues consult publications like 'Withholding and Withdrawing Life-Prolonging Medical Treatment: Guidance for decision making', BMA London, 2nd edition 2001. 'Managing Terminal Illness', Royal College of Physicians of London, 1996. 'Changing Gear: Managing the Last Days of Life' National Council for Hospices and Specialist Palliative Care Services, December 1997.