

# End-of-life treatment and care: General Medical Council good practice guidance

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**Summary** The General Medical Council's guidelines on treatment and care towards the end of life, published in May 2010, contain important guidance for all doctors, including psychiatrists, who care for patients and their families towards the end of life. The document is written in the light of the Mental Capacity Act 2005 and complements existing *Good Medical Practice* and confidentiality guidelines, also from the General Medical Council. Psychiatrists need to be aware of the communication, legal and ethical issues around end-of-life care, including advance directives and clinically assisted nutrition and hydration. This new guidance is compulsory reading for all psychiatrists.

**Declaration of interest** None.

Autumnal leaves resting on a greying background, their edges furled as if waiting to be wafted away on the slightest breeze, print in funereal lilac: the cover artwork of the General Medical Council (GMC) updated guidance on end-of-life care<sup>1</sup> points to the ephemeral and existential gentleness of nature in preference to the grim clichéd icons often associated with death and dying. Perhaps herein lies a problem. In a straw poll of a score of doctors asked 'What are your feelings when you consider end-of-life issues in your practice?', single-word answers were the norm: 'panic', 'terrifying', 'difficult'. The doctors remembered receiving this guidance book, even its attractive cover, but not one of them had actually read it. Would a more arresting design in red and black, with dread symbols of death (gravestones, death certificates, wills, etc.) release the adrenaline to open the book?

Under the cover, there is much that is welcome, helpful and important. Psychiatrists, particularly those providing services for older people or working in liaison with general hospitals or hospices, need to be equipped to deal with death in prospect, in practice and in its aftermath.<sup>2</sup> This new GMC guidance is written in the light of recent changes to legislation, including the Mental Capacity Act 2005, and legal challenges to some aspects of its predecessor.<sup>3</sup> It applies to the UK, identifying differences in legal requirements within the four constituent countries, and complements GMC guidance on good medical practice<sup>4</sup> and confidentiality.<sup>5</sup> The language is excitingly concise yet comprehensible, with a glossary of terms and three clearly separated systems of references: to relevant publications, to web-based sources of information and guidance, and to legal precedents.

## Patients approaching the end of life

The guidance states that someone is approaching the end of life when they are likely to die within the next 12 months, whether from advanced, progressive, incurable conditions, or general frailty and coexisting conditions; they may be at risk of dying from a sudden acute crisis in their existing condition or life-threatening acute conditions caused by sudden catastrophic events.

People with dementia clearly meet the inclusion criteria. Prognostication is an uncertain art, of course, and often only when wise after the event can these judgements be verified.

## Clinician's role

When death is thus imminent, the responsible clinician must register this to be the case. They must take actions which respect the values of equality and human rights, with a presumption to prolong life where there are means to do so and involve the patient throughout where they have capacity. A major development from previous guidance<sup>3</sup> is the centrality of the patient, rather than the doctor alone, in making decisions. The doctor has responsibility for outlining all options, informing the patient and other relevant parties, and maximising the capacity of the patient to deal with the information and make their choices.

## Incapacitous patients

Where the patient lacks capacity, the doctor will work with others who may have legal authority to decide for the patient, or consult the patient's advance directives, decisions or refusals. The aim will be to agree action

which will deliver the greatest overall benefit (a less restricted concept than that of best interest). Where agreement cannot be reached, advice or a second opinion should be sought and this may lead to a resolution. If this fails, then recourse to the courts becomes essential.

### Issues covered

All decisions must be recorded along with the discussion which has informed them. Decisions can be varied in the light of changes of fact and view as the situation evolves.

In 146 numbered paragraphs, the guidance offers a framework for decision-making in considering commencement or withdrawal of treatment, and how to address the uncertainty about whether such interventions are likely to bring benefit, burden or risk to the patient. Separate sections, all relevant and helpful in mental health settings, cover cardiopulmonary resuscitation (CPR) and when to consider making a decision not to attempt CPR, clinically assisted (previously 'artificial') nutrition and hydration (particularly relevant in dementia care), persistent vegetative states, dialysis, and neonates, children and young people.

The decision-making models and guidance about making sound clinical judgements, addressing uncertainty and assessing overall benefits of treatment options, will be most useful to the clinician. Communication, team working, emotional difficulties, conflicts of belief and resource constraints are discussed and guidance given on potential problems. This advice comes from, and is addressed to, doctors practising in the real world.

The definition of palliative care from the World Health Organization ([www.who.int/cancer/palliative/definition/en/](http://www.who.int/cancer/palliative/definition/en/)) seems ungainly compared with the GMC's definition, which reflects current UK practice:

The holistic care of patients with advanced, progressive, incurable illness, focused on the management of a patient's pain and other distressing symptoms and the provision of psychological, social and spiritual support to patients and their family. Palliative care is not dependent on diagnosis or prognosis, and can be provided at any stage of a patient's illness, not only in the last days of life. The objective is to

support patients to live as well as possible until they die and to die with dignity.

### Conclusion

Although this guidance is addressed to doctors, care towards the end of life is provided by many professionals within multidisciplinary healthcare teams and it is suggested that they, as well as a lay readership, may also benefit from it. The advice is applicable in many settings, including general practice, paediatrics, medicine, surgery and psychiatry – anywhere where people die. Quality care towards the end of life should be available for all, not just those known to palliative care teams.<sup>6</sup>

*Treatment and Care towards the End of Life: Good Practice in Decision Making* is compulsory reading for all practising psychiatrists. Although some may question it as a directive on details, most will find it enlightening and supportive. Open Sesame!

### About the authors

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### References

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- 4 General Medical Council. *Good Medical Practice*. GMC, 2006 ([http://www.gmc-uk.org/guidance/good\\_medical\\_practice.asp](http://www.gmc-uk.org/guidance/good_medical_practice.asp)).
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