EDITORIAL

GMC guidance will help GPs improve end of life care

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THE GMC HAS PUBLISHED IMPORTANT GUIDANCE ON THE TREATMENT AND CARE OF PATIENTS WHO are likely to die within the next 12 months.[1] The guidance takes account of the Mental Capacity Act, case law, the Government's end of life care strategy[2] and GMC guidance on consent.[3] It provides a framework for making decisions which are often clinically complex and may present ethical dilemmas, and for the first time provides guidance on advance care planning.

Ethical dilemmas can be addressed by the application and balancing of four moral principles: respect for autonomy, beneficence, non-maleficence and justice.[4] Of these, respect for autonomy is pre-eminent: patients have the right to refuse treatment even if they are likely to die without it.

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We should work in partnership with competent patients in accordance with the GMC guidance on decision making. Difficulties may arise where patients request treatment, such as artificial hydration in the last days of life, where the potential harm outweighs the benefit.[5] If there is a fine balance between benefit and harm, we should usually comply with the patient's request, but we are not obliged to provide treatment that we consider to be clinically inappropriate.

For patients who lack capacity, we must check their records to see if an advance decision has been documented and enquire whether they have appointed an attorney. When there is no attorney and we are responsible for decision making, we must consult those close to them regarding their wishes, views and beliefs.

There are a number of important components of a good death, including effective symptom management, achieving a sense of control, being respected as an individual, and spending meaningful time with close family and friends.[2,6,7] Sadly, many patients do not die the death they would have chosen, either because of inadequate planning or because they have lost the capacity either to make or communicate decisions about their treatment. We need to identify patients who are approaching the end of life and encourage them to participate in advance care planning. This should include a statement of wishes, preferences, beliefs and values, which has legal standing and must be taken into account in the event of incapacity.[8] Patients may wish to take out a lasting power of attorney or they may wish to refuse specific medical treatments through a legally binding advance decision. We should discuss their preferred place of care and ask about spiritual needs.

The difficulty with advance decisions is that the terminology is ambiguous. There may be doubt as to whether a situation is 'life threatening' and we cannot be certain whether our interpretation of phrases such as 'futile treatment' corresponds with that of the patient.[9]

One in three persons over 65 will die with dementia. Providing they do not develop cancer or organ failure, these patients will typically experience a gradual decline over several years.[10] It is important to discuss their end of life care before they lose capacity; in view of the limitations of advance decisions, they may prefer to appoint a personal welfare attorney. A controversial issue is the use of gastrostomy tubes to provide nutrition and hydration for patients with advanced dementia. The GMC advises that we must provide this if we judge that it would be of overall benefit. However, current thinking is that the potential harm, in particular the need for restraint, outweighs any benefit and that tube feeding is seldom justified.[11,12]

So far as is possible, we should try to preserve patient autonomy and minimise the role of paternalism. Advance care planning allows us to identify and respect our patient's wishes, and thereby improve care at the end of life, enhance family satisfaction and reduce the risk of depression in surviving relatives.[6]

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