End of life guidance

Expert views on withholding life-prolonging treatment
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GMC Contacts

EDITOR
Jane Janaway
jjanaway@gmc-uk.org

GMCtoday QUERIES
gmc.today@gmc-uk.org

REGISTRATION ENQUIRIES AND CHANGES
0845 357 3456
registrationhelp@gmc-uk.org

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Sir Graeme Catto
President, GMC

This issue of GMCtoday explores a number of interesting issues, with the main focus on the GMC’s Withholding and withdrawing treatment educational campaign. You will remember that in relation to the ruling in the case of Mr Leslie Burke, the Appeal Court recommended that our guidance should be ‘vigorously promulgated, taught, understood and implemented at every level and in every hospital.’ With this issue is a short guide to indicate the issues involved.

As we are no longer making addresses publicly available, we are encouraging doctors to display their GMC reference number and registered name so that they can be accurately identified.

Both of these issues are important and I hope that you find these articles informative.

Valuing diversity: online resource guides

The GMC has developed a set of valuable resource guides to provide information and advice on diversity and equal opportunities.

The guides provide practical tips and links to a comprehensive selection of websites covering issues that may arise in your work.

They can be accessed at www.gmc-uk.org by selecting ‘Guidance’, then ‘Valuing Diversity’. Subjects covered are:

→ anti-discrimination legislation
→ age discrimination
→ beliefs/religion
→ disability
→ race equality
→ gender
→ effective communications
→ employment relations
→ human rights
→ sexual orientation
→ working with colleagues

Comments on this new resource are welcome and should be sent to secretariat@gmc-uk.org
List of Registered Medical Practitioners

In the last edition of GMCtoday, we brought you news of changes to the format of the Register. The new online List of Registered Medical Practitioners, together with the new GP Register, went live successfully at midnight on 31 March. The List of Registered Medical Practitioners, which is in the public domain and which has replaced the former Online Doctor Search, includes the names of all doctors registered with the GMC and gives details of:

- doctors’ reference numbers, names, any former names, gender
- year and place of primary medical degree
- registration status
- date of registration
- entry in the new GP or the Specialist Register
- any publicly available fitness to practise history.

You can access your entry at http://webcache.gmc-uk.org/ods/home.do

Doctors’ addresses are no longer in the public domain. We may be asked to provide your registered address to the British Medical Association, medical defence organisations, and medical royal colleges and faculties so that they can keep their records up to date. We will only do so, where we are satisfied you are already a member. If you would prefer us not to share your registered address with these organisations please let us know either by sending an email to registrationhelp@gmc-uk.org or by writing to Registration Update Team, General Medical Council, St James’s Buildings, 79 Oxford Street, Manchester, M1 6FQ.

Signing up to the Healthcare Concordat

The GMC is among a second wave of organisations who are to become formal signatories to the Healthcare Concordat. Led by the Healthcare Commission, the Concordat is a voluntary agreement between organisations that regulate, audit, inspect or review elements of health and healthcare in England. It co-ordinates and improves the impact and value for money of this activity.

All signatories are supporting the improvement of health services for the public, by streamlining their activities so that those working on the front line are not overburdened by regulation. There is a similar agreement for bodies in Wales which carry out reviews and the GMC hopes to sign up to this agreement later this year.

The Concordat lists 10 objectives aimed at:

- delivering more consistent and coherent programmes of inspection
- improving services for patients, clients and their carers
- reducing unnecessary burdens of inspection on staff providing healthcare.

Visit www.concordat.org.uk for details about the Concordat.

This website includes a scheduling tool which allows signatory bodies to co-ordinate their visits to healthcare providers. An e-hotline has also been developed allowing managers or clinical staff working in front line health services to raise concerns about the planning and handling of external inspections, audits or other types of review of their organisation: concordat@healthcarecommission.org.uk

Other tools support the implementation of the Concordat enabling signatories to fulfil their respective functions, maximise the benefits of activities and reduce the overall burden on health and social care providers.

One of these is an information map where signatories list all of the data they collect about healthcare organisations so that they can identify and manage duplication. For example, as a result of this tool, the NHS Litigation Authority has been able to completely remove an annual survey, saving an estimated 600 days of NHS time per year.

An example of work the GMC is doing which fits in with the Concordat principles is our development of the Quality Assurance of Foundation Programme (QAFP) jointly with the PMETB. This work is still at an early pilot stage, but when it is fully implemented it will allow both bodies to fulfil their separate statutory obligations through a single streamlined process.

In addition to being Concordat signatories, the GMC and the Healthcare Commission are currently developing a bilateral agreement to reflect working practices between the two organisations; key features will be exchange of information on fitness to practise and other issues.
The GMC has been working with the Department of Health and the Junior Doctors Committee of the BMA on a survey of UK qualified doctors who were first registered in 2003, 2004 and 2005. The result of the survey is now available. GfK NOP carried out the research on our behalf. They conducted telephone interviews with 1000 graduates from each cohort, and we are grateful to those who took part for their time and contribution.

The survey showed, amongst other things, that 99% of the 2005 graduates interviewed were in work, as were 93% of the 2003 and 2004 cohorts. Of the 1% of 2005 graduates not in work, over half were not working by choice. Over 90% of those interviewed were committed to a long-term career in the NHS.

The peak time for starting employment was in the summer, in August. Medicine, surgery, A&E and General Practice were popular specialty posts for the UK graduates. The UK regions and nations in which most employment was obtained were London, followed by Scotland and the North West.

Visit www.gmc-uk.org/news to read the full report of the survey.

Survey of recent UK graduates

Results of GMC UK graduate survey now available

The GMC has been working with the Department of Health and the Junior Doctors Committee of the BMA on a survey of UK qualified doctors who were first registered in 2003, 2004 and 2005. The result of the survey is now available.

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Visit www.gmc-uk.org/news to read the full report of the survey.

Amendments to the Medical Act

As was reported in the recent special issue of GMCtoday, the Department of Health has recently consulted on proposed amendments to the Medical Act in relation to the GMC’s registration function. The consultation also included some proposed amendments to the GMC’s education function. The proposed changes would allow the Education Committee to:

→ quality assure provisionally registered training separately from undergraduate medical education

→ identify which institution or body we will be approving to deliver training for this year

→ specify the outcomes that must be completed before a provisionally registered doctor is allowed to take up full registration with the GMC.

These amendments are needed before the Education Committee is able to require that the standards and outcomes laid down in The New Doctor are met, or before they are able to make requirements under the Quality Assurance of the Foundation Programme. Please email qafp@gmc-uk.org if you would like further information.

Calling all medical schools

It will be soon be time for you to order your Duties of a Doctor packs, an order form will be sent out to you in May.
Following the publication of the out-of-hospital care White Paper, there has been a mixed reaction to the Government’s plans to shift the emphasis of care from hospitals to the community.

The Government wants to see more care carried out by GPs, nurses and other healthcare professionals working outside hospitals. Among the measures proposed are for GPs to open their practices for longer and to set up specialist clinics for conditions such as diabetes and ear, nose and throat treatment.

The private and voluntary sectors are also being encouraged to get involved in the NHS community market, with high street stores and supermarkets hosting health clinics.

The first medical centre where commuters can get a free check-up before catching a train has opened at Liverpool Street station in London. It is the first of four planned for the city. They will be open from 7am to 7pm in the week so that patients can see a doctor free of charge, without an appointment.

Trained as a GP, now practising as a specialist registrar in psychiatry, David Bickerton comments: “I broadly welcome the White Paper. Most life and illness takes place in primary care or the community therefore it is only logical for most healthcare to take place there too.

“Most care activities can and should be performed in the community although certain risk or clinical factors mean that hospital facilities are sometimes needed. Clearly this re-provision of service will require a huge re-provision of resources which is likely to generate friction at the primary/secondary interface.

“Mixed in with this message is an opportunity for other care providers to trade their wares including the voluntary sector.

“As for practices opening at more convenient times I am all for it. I would be prepared to run outpatient clinics at more convenient times.”

David Bickerton

“There has for some time been an insidious dumping of services from secondary care onto primary care, and GPs are left to pick up the pieces. Diabetes was pushed our way a couple of years ago, and respiratory disease, minor surgery, venesection soon after. None of this is ever followed by any money so we have never been properly remunerated. The ethos seems to be ‘let the GP pick up the pieces, and don’t pay him for his troubles.’

“The new GMS contract promised a better lifestyle for more money, and for the first time we have been paid for the work we do according to our professional status, ie equivalent to solicitors, accountants, etc. But this has been underpinned and eroded by the addition of new QOF targets to this year’s contract – for no extra money. GPs will see their pay slide year-on-year, and our accountants warn of doom and gloom. PMS practices are not immune to this perilous state either.

“The final straw is the move to make GPs open their surgeries into the night, and at weekends. Bang goes the one attractive feature of the new contract where for the first time since 1947 we were able to opt out of out-of-hours.

“What a big U-turn by the Government. GPs will only agree to work these extra hours for proper remuneration – and so this is another nail in the coffin for the demise of the cash-strapped NHS.

“Private providers will have to step in – but they too will name their price.

“There is no other option, and I think most GPs believe (if they are truly honest) that the days of the NHS are numbered.”

Michael Barrie GP, Kingston-Upon-Thames

“I guess people want a kind of ‘supermarket healthcare’ system – where they go and get what they want when they want it. So having GP surgeries opening longer hours with convenient appointments could be a good idea from the patient’s point of view.

“Also it could help some patients who need to receive three to five day courses of treatment, which could be administered by a specialist nurse or at their GP surgery.

“There would be better communication between hospitals and GPs and community healthcare, and more emphasis on people taking responsibility for their own health.

“However I think a lot of diagnosis and treatment depends on radiology investigations, which means going to local hospitals anyway.

“I think GPs will increasingly feel they need to refer patients to their local A&E department, if they have any suspicion of any underlying serious condition.

“I might also be a bit concerned about GPs based in supermarkets, as pressure could be put on to prescribe those drugs which the supermarket makes most profits from, in which case could be more expensive healthcare.”

Stephen Bridgett Locum SHO

Do you think there is a failure of recruitment to GP work?

Email gmctoday@gmc-uk.org with your views.
Facing the facts

Putting patients in the picture on cosmetic surgery

Patients need to make informed decisions about cosmetic surgery, but this isn’t always easy. There is plenty of good information available, but it can be difficult to find, and hard for patients to know what to trust.

Cosmetic surgery is on the increase. More and more people seem influenced by celebrities they see on television or in magazines, who can afford to pay for cosmetic surgery to keep themselves looking younger for as long as possible.

Non-surgical procedures are increasing as well, with botulinum toxin - Botox® - and dermal fillers readily available on many local high streets.

Patients need to make informed decisions about cosmetic surgery, but this isn’t always easy. There is plenty of good information available, but it can be difficult to find, and hard for patients to know what to trust.

This is where doctors can play a key role, helping patients reach a decision that is right for them.

If doctors could make patients aware of the Department of Health’s website, www.dh.gov.uk/cosmeticsurgery the patient can then be better informed before visiting their surgery. They will also have some useful questions to ask at any future consultation with a surgeon.

The website has:

- questions for patients to ask providers, clinics and surgeons
- a page on the qualifications held by cosmetic surgery practitioners
- detailed pages on nearly 50 surgical procedures and non-surgical treatments
- information about how to complain if things go wrong.

The website was launched by Chief Medical Officer of England Sir Liam Donaldson. He is very keen to see improved patient safety in cosmetic surgery and providing better information for patients – and doctors – can help to do this.

Sir Liam said: “Good patient information on cosmetic surgery is essential. People need help and support to make informed choices about whether to have cosmetic surgery or a non-surgical treatment. And a well informed patient can help to drive up standards among providers.”

The material on the site was developed with the help of key stakeholders in the cosmetic surgery field. It has the support of doctors and surgeons who carry out cosmetic surgery.
Contact centre 0845 357 3456
registrationhelp@gmc-uk.org
All registration queries can be dealt with by our trained operators on the above number. Here are some additional hints and queries on services available and how to access them via email and the website.

Q What are the opening times of the contact centre?
A The centre is open Monday to Friday between 08:00 and 20:00, and Saturday from 09:00 until 17:00.

Q What type of queries do you deal with?
A We deal with all general enquiries specialising in registration, including the different routes, how you move from one type of registration to another, fee enquiries, etc, but will endeavour to answer any question regarding the GMC. If we are unable to help directly we will put you in touch with the relevant department. We also deal with all enquiries by email, which many doctors find is a convenient way of contacting us.

Q How can I pay my annual retention fee?
A You can pay this in three ways:
By sending a cheque to: GMC Fees Finance, St James’s Buildings, 79 Oxford Street, Manchester M1 6FQ.
By direct debit – you have the option to pay in either four equal instalments or one annual payment.
Online by debit or credit card via our website (MyGMC) as below.

Q How do I access MyGMC?
A You need a GMC number and a pin and password to access MyGMC. You can either call or email our contact centre, quoting your GMC reference number, and they can be sent to you by post.
Withholding life-prolonging treatments
Debating the ethics

The Appeal Court ruling in the case of Mr Leslie Burke has helped clarify the vital role played by the GMC in ensuring that doctors maintain good standards. The Court of Appeal recommended that our guidance Withholding & Withdrawing Life-prolonging Treatments should be ‘vigorously promulgated, taught, understood and implemented at every level and in every hospital’.

In response to the ruling the GMC is embarking on an educational campaign, launching today with publication of a pocket booklet containing extracts from the guidance and key principles (enclosed with this issue of GMCtoday). We are also sponsoring educational events for clinicians around the UK, initially in Belfast, Birmingham, Edinburgh, London, Plymouth and Swansea.

Organisations beyond clinical multi-disciplinary health teams often become involved in looking after patients’ interests. Recognising this, we are also organising patient support workshops linked to the educational events. These workshops will give the chance for those who support patients at the end of their life to engage directly with the GMC and to share experiences.

The judicial review of the GMC guidance highlights the importance of establishing an effective partnership between patients and doctors for decision-making at the end of life. Articles in the media have reflected patients’ worries about how they may be treated when they are no longer able to express their own wishes.

Mr Burke’s case shows how important it is for doctors to communicate clearly with patients about their condition and prognosis, and the options open to them. It highlights the importance of listening to patients so that their beliefs, wishes and views can be reflected in decisions taken when patients can no longer speak for themselves.

GMCtoday sought the views of experts from three different organisations.

The Disability Rights Commission’s view
The key issue for the Disability Rights Commission (DRC) when situations involve the withholding or withdrawing of life-saving treatment is who, in the final analysis, has the last word on what is in a patient’s best interests. This is particularly important in situations where the patient lacks capacity and there are disagreements over the impact and consequences of giving or withholding life-prolonging treatment.

Despite the legal technicalities in this area it is clinicians who are left with the difficult job of making the right decisions and implementing good practice, often in difficult circumstances and at very short notice.

There is no doubt that doctors and other professionals who are charged with the responsibility for making life and death decisions recognise the gravity of these dilemmas. Nevertheless, it is surely legitimate to ask whether the tools they have at their disposal are always sufficient to determine whether a course of treatment, or its cessation, is in a disabled patient’s best interests.

Clearly, it is the legitimate domain of clinical competence to make an assessment of the likely physical consequences of a particular medical intervention – provided that this expertise is exercised in
Focus on the individual circumstances and wishes, examine the evidence

The GMC’s guidance on withholding and withdrawing life-prolonging treatments came in response to requests to provide guidance on good practice and one of the most contentious areas is artificial hydration and nutrition. The taking of fluids and food is extremely symbolic in our society. Many people see food and fluid as an essential part of sustaining life and, even in the face of terminal illness, carers may equate the giving of food with giving love (just as parents provide food for their children). These are natural and normal reactions and need to be considered and discussed.

Hydration and nutrition are often lumped together as if these two interventions were equivocal. This is not the case. Loss of fluid and dehydration if acute and severe can bring about electrolyte intolerance, adverse drug reactions and confusion. In gradual onset dehydration at the end of life, the value of hydration is not clear. Thirst has many causes and can be treated by other means than fluids [Morita T et al 2001; Sarihill N et al 2001; Ellershaw J E et al 1995]. But a terminally ill patient may benefit from subcutaneous fluids if they are suffering symptoms, such as confusion, because of dehydration. On the other hand, overloading fluid can cause different symptoms, including pulmonary oedema and incontinence. Nutritional support may slow down nutritional degradation and promote rehabilitation, especially in patients with a longer life expectancy. There is no evidence though that it is helpful in terminal illness.

The giving of artificial hydration and/or nutrition is clinically warranted when it is the patient’s particular request and when it is likely to give more benefit than to do harm. The role of the clinician is to weigh the potential risks and burdens of treatment against its potential benefits. Appraising the potential likely benefits versus the risks, burdens or side effects is not about making a judgement of the patient’s quality of life. It should involve a team discussion, understanding the person’s prior preferences if these have been made clear. Advance directives can be helpful, but they may not cover all eventualities and individuals may not make them. Also, human beings adapt to their situation, and may change their request as they become used to different circumstances. All of this adds up to an indication that the assessment must be made, in consultation with the patient and family, weighing the benefits and potential risks or burdens of any individual treatment in an individual situation for an individual person. There is also an urgent need to learn more about the benefits and burdens of these treatments, the management of symptoms and how people express their wishes, especially as medicine advances.

Professor Irene J Higginson
Department of Palliative Care, Policy and Rehabilitation, King’s College London

A breath of fresh air

Critical care ventilators have a button to allow a pause in respiratory support. For intensivists, who must frequently make decisions about which patients should be admitted to an Intensive Care Unit (ICU), the initial ‘Burke case’ judgement was analogous to this button being held down, producing a collective ‘inspiratory hold’.

Paradoxically, it was not the right to receive respiratory support that led to the challenge of the GMC guidance, but Mr Burke’s concern that he might be denied nutritional support and fluid therapy (unfortunately referred to as ‘life support’) if hospitalised. In acute medical care this terminology is generally linked to the word ‘machine’, therefore implying mechanical ventilatory assistance. This association, and the implication that by extension a ruling against GMC guidance would enable patients to insist on interventions not supported by consensus medical opinion, generated huge concern for those working within limited critical care resources. As one colleague commented: ‘If this goes the wrong way we will need three times as many ICU beds, and you can forget elective surgery’.

Anticipating the potentially devastating effect of an adverse Appeal Court ruling, the Intensive Care Society, which represents the interests of critically ill patients and of staff who work in UK ICUs, provided clarification to the Court on the distinction between ‘life support’ and the more appropriate terminology ‘artificial nutrition and hydration’ (ANH). The implications for the NHS of undermining the ‘gatekeeper’ role of intensivists were also highlighted.

The appeal outcome was awaited with a sense of trepidation. Although there was widespread belief that the appeal had to succeed in the interests of the wider public, in critical care medicine ANH is generally a basic pre-requisite of supportive care. Even when it is clear that treatment is futile, its withdrawal or withholding is seldom (if ever) contemplated as a means of allowing nature to take its course.

When the GMC guidance was upheld (and supported by the recent House of Lords’ decision not to accept a subsequent appeal), ‘inspiratory hold’ was released. With a collective sigh of relief, we can breathe again, and focus on preserving scarce resources for patients who, temporarily, can not!

Dr Bruce Taylor
Consultant in Critical Care Medicine, Chair, Intensive Care Society Standards Committee, Editor, Journal of the Intensive Care Society (JICS).
The approved working environment is a key concept in our proposed revalidation model. We are developing templates for assessing local processes and controls and determining whether they meet the criteria for approved working environment status. Last year we visited Wales and Scotland to gather information about the appraisal and clinical governance systems in place there.

We continued with this programme of work with a visit to Northern Ireland. The GMC team was led by Council member Dr Malcolm Lewis, and observers from Wales and Scotland joined us to share experience and discuss best practice. We had productive discussions with the Acting Chief Medical Officer, Dr Ian Carson, Department of Health, Social Services and Public Safety (DHSSPS) staff and the Regulation and Quality Improvement Authority (RQIA), as well as a group of medical directors and GP appraisers.

Northern Ireland has a well-established GP appraisal system. To improve the coordination and consistency of this further, management responsibility for the GP appraisal system became a function of the Northern Ireland Medical and Dental Training Agency in April 2006. The DHSSPS is about to consider the findings of a review of the medical appraisal system.

The DHSSPS has also developed Quality Standards for Health and Social Care and these will be used by the RQIA to assess the quality of care provided by the DHSSPS from 2006.

**Jersey visit**

We have also recently visited Jersey. Although the healthcare system in Jersey is outside the NHS, doctors are required to be registered with the GMC to practise medicine there. It is envisaged that in future doctors in Jersey will need to be licensed in order to retain their practising rights.

A GMC team, led by Council member Mr Rob Slack, met with Mr Mike Pollard, Chief Officer of Health and Social Services in Jersey, members of the Board of Heath and doctors from both primary and secondary care.

We look forward to continuing to work in partnership with our colleagues so that we can deliver a co-ordinated and effective regulatory system.

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**Business Plan published**

The GMC recently published its Business Plan. Visit [www.gmc-uk.org](http://www.gmc-uk.org) to see it online.

Our first aim is to continue to develop the GMC’s capacity to be a proactive regulator, focused on establishing, maintaining and promoting high standards of medical practice throughout doctors’ careers.

We will be publishing a revised version of *Good Medical Practice*, which will reflect the changing environment and the increasing emphasis on partnership with patients. We will also:

- publish a report on the outcomes of the consultation on strategic options for undergraduate medical education
- review the strategy for undergraduates’ fitness to practise and quality assurance systems.

Our second aim is to regulate more effectively and efficiently and in ways that increasingly enable us to fully engage with those who use or benefit from our services.

We will:

- develop stronger strategic relationships with employers of doctors and other partner organisations
- lead the examination of the feasibility of a single complaints portal
- develop proposals for a risk-based approach to regulation.

Our third aim is to make the arrangements for registering doctors fairer and more robust, and make registration information more accessible to patients, the public, NHS organisations and employers of doctors. We are also:

- working to secure agreements to enable information sharing with regulators in other countries
- extending online services by making additional information available via secure access to employers of doctors and enabling all doctors seeking registration to apply online
- establishing a GP Register and completing the review of the Specialist Register
- preparing for the introduction of revalidation and the licence to practice.
Bringing public petitions to Parliament

The establishment of a dedicated Public Petitions Committee has been one of the most successful innovations in the Scottish Parliament, offering an open and transparent route by which the community can bring issues of interest directly to the parliamentary table. Part of that route is an award-winning e-petition system which has inspired the German Bundestag to pilot this approach.

The petitions are discussed in committee and relevant parties are called on to submit input. The issues often land on ministerial desks or form the basis for debate in other committees or even full parliamentary debate. In response to one particular petition, the First Minister, on behalf of the people of Scotland, went on to offer an apology to all individuals who suffered from institutional child abuse.

Committee Convenor, Michael McMahon, MSP, is passionate about the contribution the public can make to the parliamentary process, saying, “As we approach the 1000th petition to be lodged in the Scottish Parliament there is little doubt that the public petitions system has been one of the success stories of devolution. Petitions covering all aspects of the devolved settlement from every corner of Scotland has meant that the Public Petitions Committee has consistently been among the busiest committees in the Parliament. Built on the Parliament’s core principles of openness and accessibility the Committee has invited hundreds of petitioners to give evidence in a relaxed and welcoming environment and with an opportunity to have a genuine impact on the political process.”

Fringe meeting

Around 18% of petitions lodged at Holyrood are on health-related matters, ranging from specific resource allocation issues to calls for the Parliament to reflect on how professional regulation and patient safety should be addressed. These issues also formed the ‘Patient Voice – Public Interest’ theme of the GMC Scotland fringe meeting at the recent Scottish Labour Party Conference in Aviemore.

Michael McMahon was joined on the panel by Jackie Burman of Citizens Advice Scotland (both pictured right). Jackie looked at the new arrangements enabling Citizens Advice Bureaux across Scotland to offer real support to members of the public who wish to raise concerns or complain to the NHS. The packed meeting debated how the wider community can communicate effectively with the Scottish Executive and the health sector. It was agreed that it is not easy to hear the views of the public and professionals but that this must be central to the development of effective healthcare delivery. Parliamentary debate on issues such as workforce planning is enhanced by the vibrant public petitions route and further underpinned by the direct public and patient involvement work carried out by bodies such as the GMC and Citizens Advice.
Following on from issue 6 of *GMCtoday*, which featured an article on people with asthma, Asthma UK and the General Practice Airways Group (GPIAG) are launching an asthma control awareness campaign.

In the run-up to World Asthma Day – Tuesday 2 May – Asthma UK and the GPIAG are campaigning to increase awareness of control in people with asthma.

**ACT**

The two organisations are launching the Asthma Control Test (ACT™) in the UK, a simple 5-point questionnaire which is self-completed by patients to give them an asthma control score.

A recent survey showed that 91% of respondents believed that their asthma was well controlled yet two-thirds were experiencing asthma symptoms 2–3 times per week or more. (*The Living and Breathing Study: A study of patients’ views of asthma and its treatment*, Haughney J, Barnes G, Partridge M, Cleland J. Primary Care Resp Journal 2004; 13: 28-35.)

Asthma UK is encouraging people with asthma to complete the ACT and then to visit their GP or asthma nurse if their score indicates that their asthma could be better controlled.

**Take exercise**

Patients can also help themselves by taking exercise and staying fit to keep asthma symptoms under control.

Four out of 10 people with asthma say their condition can stop them from exercising, yet research shows that active people can control their asthma symptoms more effectively and enjoy a healthier lifestyle.

Asthma UK produces a guide to exercising, *Stay fit and active*, which offers advice to people with asthma on tackling sports and physical activities safely.

Tips offered in the guide include:

- always carry your reliever inhaler with you when you exercise
- try to avoid your triggers such as pollen warming up and down will help to avoid asthma symptoms developing.

“Research is showing us that asthma is not a barrier to exercise and fitness, and also that staying active has a really positive impact and helps people to keep their symptoms under control,” said Erica Evans, Asthma UK’s Asthma Care Development Manager.

**Deadly serious**

The World Asthma Day campaign follows on from the Deadly Serious campaign, launched in March when a survey carried out by BRMB revealed that only half of the people questioned knew what to do if someone was having an asthma attack.

This startling finding is in spite of the fact that the same survey found that 93% of people know that an asthma attack can be fatal. The campaign included a television advert to highlight that underestimating asthma to complete the ACT and then to visit their GP or asthma nurse if their score indicates that their asthma could be better controlled.

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Asthma UK wants everyone with asthma, or who cares for someone with asthma, to have an Asthma UK Asthma Attack Card, which contains basic information about what to do in an asthma attack.

**How you can help your patients**

Asthma UK and the GPIAG will be jointly writing to 70,000 healthcare professionals across the UK to alert them to the World Asthma Day campaign and remind them of the actions to take when a patient comes in with poor control. *The British Guidelines on the Management of Asthma* recommend that asthma control should be assessed by healthcare professionals using the Royal College of Physicians (RCP) three questions.

Asthma UK’s *Be In Control* materials are also recommended by *The British Guidelines on the Management of Asthma*. These include a written personal asthma action plan to help get and keep your patients’ asthma under control. Australian research shows that having your own written asthma action plan can reduce the risk of a fatal asthma attack by 70%. (*Am J Respir Crit Care Med 2001; Jan 163 (1): 12-18*).

For copies of Asthma UK’s *Be in Control* materials email info@asthma.org.uk or call 020 7786 5000.

Visit www.asthma.org.uk or further information about asthma.
NICE should be part of the GMC

The inception of the NHS in one single political stroke also created the world’s largest purchaser of all items pertaining to the care of patients. This gave a negotiating power of which even the largest corporation could only dream.

Instead, in one of those indulgences which are enjoyed only by governments, an open cheque was written to all who supplied any form of goods or service. The beneficiaries of this bonanza hastened to use every artifice of salesmanship, publicity, etc, to further their interests – even including, where considered useful, corruption and bribery. The latest of these strategies is now the release of incomplete and dubious snippets to the media to stir the public to demand the ‘latest treatment’. However, in the cruel commercial world these companies also knew that ‘one has to keep running to stay in the same place’; and the wiser embarked on huge investments in research.

Indeed, the present state of medicine owes most of its progress to this investment. This was welcomed by not only the researchers themselves but by other bodies such as universities who took as much as 25% of the money for their own funds. Unfortunately even more money was spent, not on basic progress, but on seeking for what are known as ‘me too’ drugs and goods, so keeping up with the rival companies or in the discovery of more expensive substitutes for simple established preparations – even if they are less effective than those already existing.

Nor was the profession entirely free of blame for one does not readily bite the hand that feeds and some were found who were willing to be economical with the truth or even to distort it. And so, several decades belatedly the National Institute of Clinical Excellence (NICE) was born.

NICE, however, has one major defect – it has no teeth! This could easily be altered if it were to be incorporated into the GMC. Then, any researcher could be summoned to present results and methods knowing that if they were found to be falsified or distorted the perpetrator would face the ire and censure of the GMC itself. Those companies who attempted to evade this by using foreign researchers could face the obligation to produce them before the GMC’s body to justify the work or face non-authorisation of the product by NICE. Only the dubious would refuse.

It is therefore my proposal that NICE ought to be incorporated under the GMC as soon as possible.

George T Watts, Ch M FRCS Birmingham

To freelance or not to freelance?

Despite the omission of the NHS from this year’s budget, the Government’s full report could have an unexpected impact on those working within the medical profession. The announcement to progress a consultation into addressing ‘disguised employment’ status will have serious implications for many locums. Practitioners particularly vulnerable to the increased threat of IR35 investigation will be those working through limited or managed service companies, receiving their salaries as dividend payments. This is concerning as independent research has revealed that up to 75% of contractors, including locums, do not understand the tax and legal implications of working freelance.

Ostensibly, current tax guidelines for contractors are in place to prevent the avoidance of tax and National Insurance contributions. However, Government scrutiny should be welcomed to help regulate the industry and protect practitioners from being misled by unscrupulous service providers or through genuine misunderstanding.

To ensure that locums do not fall foul of these regulations, they should review their tax arrangements if they are on a temporary assignment and seek advice from a reputable provider of taxation services for contractors.

Tim McMillen Prosperity4 Ltd, Luton.

Test your skills

1 In staphylococcal toxic shock syndrome, which one of the following is a characteristic feature?
   A) bacteraemia  B) cellulitis  C) desquamation of skin  D) lymphadenopathy  E) nasal colonisation with MRSA

2 A 70-year-old woman was admitted with a two-day history of pain and swelling of the right ankle. There was no history of trauma or preceding infection. On examination her temperature was 37.8°C and her right ankle was swollen, tender to palpation and had a reduced range of movement.

Which investigation will be most helpful in establishing the diagnosis?
   A) aspiration of the right ankle  B) blood cultures  C) ESR  D) plain X-ray of the right ankle  E) serum urate concentration

Don’t be afraid of an exam

After reading Dr John’s article in the Special issue of GMCtoday, I wish to give a contrary view.

My appraisals so far have been pleasant and vaguely pastoral but have not been able to assess my skills, knowledge and attitudes as a GP, nor my learning needs. The former are what the lay public rightly want assessed, and the latter are what I need to work on to keep up my skills. I am not subjectively aware of the gaps in my skills and knowledge – these need an objective examination, and my consultation skills need to be assessed by the videoing of actual consultations.

In the current climate in primary care GPs are not the only healthcare professionals interested in providing care directly to patients. GPs, however, have the broadest knowledge of any healthcare professional and the experience to be able to apply that knowledge.

They therefore have nothing to be afraid of, and a lot to gain, by demonstrating their knowledge in an objective examination that can also be used to identify areas for further learning and training.

Dr Paul Burgess MRCGP MA DCH

GP Principal and Trainer, Gosport Health Centre
Elements of Medical Law

Charles Foster

This book covers aspects of the law most likely to impact on clinicians – those relating to the beginning and end of life, and core topics such as negligence, consent and confidentiality. It is surprisingly jargon-free, making it accessible to readers with just a limited use in other contexts, especially in terms of influencing future behaviour. I find it disappointing that a more imaginative take is not evident in the author's reasoning and analysis, and underlying this is an assumption that for something to be legal it must also be ethical. No mention is made of that assumption, and he goes so far as to say that GMC guidance on seeking patients' consent, which reflects both ethical and legal principles, has 'absurdities [that] come crawling out' (p.45). He is entitled to his view but, unsurprisingly, it is not one I share.

Roger Worthington PhD  Adviser, GMC Standards and Ethics

Short drive to golf courses. From £250 per week. Tel Sharon or John on 01500 815616 or email: sais@spkmn.freeserve.co.uk

FOR RENT

Dordrice, Solihull: 2 bed modern flat. Fully furnished £525 pcm excluding rates and bills. Fully equipped kitchen, Shower room. Large lounge/dining room. Central heating. Nr station and Birmingham hospitals. 5 mins from M42. Tel: 01905 354986. email: 106565.3342@compuserve.com

Furnished single room: £300pcm part of a house-share. Located in Mitcham close to hospitals such as St. George's, Mayday and close to the A3 (Royal Surrey County). Space available for parking. Looking for non-smoking female medic. Tel: 07956 91 4074.

For sale

Leicester, 3 bed terraced: Victorian bow-fronted terrace with lounge and separate dining room, extended kitchen, 3 beds, 2 baths. Near all schools and amenities. 15 mins from Glenfield Hospital. 10 mins from the Royal Infirmary & 5 mins from the General Hospital. £134,950. Tel: 07921540014; email: bhavik112@hotmail.com

London N7: Luxury 3 bed apt in gated complex. 2 bath (1 ensuite), open plan kitchen with all mod cons, lounge, utility room, private garden and large communal garden, off-road parking and bike shed, nr Holloway tube, buses and shops, 20 min from city centre. Tel: 07096760369; email: motalashash@yahoo.com

MISC

REUNION. Christ's College, Finchley: Keep in touch with medics from your old school through the Finchleian Medical Club (founded 1950) at the Annual Dinner at The Athenaean Club, London. email: darryltant@ntworld.com, or: 01582 763362

If you wish to advertise in Dr to Dr, simply email gmtoday@gmc-uk.org with the details. Ads are free and are allocated on a first-come-first-served basis. The copy deadline for the June issue is 15 May 2006.

HOLIDAY ACCOMMODATION

- Auchtermuchty, Fife: Elegant Pitcairnie House. Enjoy 4-star luxury within the Victorian Wing of the main house set in beautiful parkland and woodland. 30 to 40 mins to St Andrews, Glen Eagles, and Carnoustie. Ladybank only 10 mins. 4 apartments and 1 Lodge House, which sleeps 3 to 6. All mod cons, ensuite bathrooms and the use of heated pool and sauna. email: jrosemaryj@aol.com
- Dunkeld, Perthshire: 2 bed, well-equipped timeshare lodge (sleeps 6) in the grounds of the Hilton Dunkeld. Full use of leisure facilities and numerous walks in forests and river areas. 1-2 hour drive from Edinburgh. Pets allowed. Lodge 16, week 43 (Hallowen) Price negotiable. Tel: 07837334341 or email lmc@cheltenhain@yopub.uk
- France, Mediterranean Coast: Luxury mobile home. No smokers/pets. Sleeps 4. Pool. Near beaches. Tel: 01296 620370. E-mail: mrsau2th@yahoo.co.uk.
- Franchoek: Cape Province, South Africa. Delightful fully equipped BB cottage sleeps two. In a private vineyard with mountain views. £70 a day. Email: vnkerk@telkom.net
- Golf in the South African wild: Championship course with luxury bush lodges and local rules for antelope and giraffes. Also hotel with all sports amenities. 1 hr by air from Johannesburg airport. Adjoins Kruger National Park, hot Linked by the Kruger Park Game Reserve, offers fine golf, lion and giraffe. Also hotel with all sports amenities. 1 hr by air from Johannesburg airport. Adjoins Kruger National Park, hot Linked by the Kruger Park Game Reserve, offers fine golf, lion and giraffe. Tel: 01905 354986. email: 106565.3342@compuserve.com
- Greek island: Idyllic villa, sleeps 6. 50 m from sea and private jetty for swimming. £700 per week August/Sept. Contact whigham@oldkit.fonet.co.uk
- Lake District: ‘Riverside Retreat’. Luxury cottage for four, outskirts of Ambleside. All mod cons, parking, bike store. Free leisure club membership during stay. email: ulia.maloney@btih.co.uk
- Liguria, Italy: Medio, spacious villa with 300sqm living space and 10,000sqm terrace land around house, sleeps 10+2 (4 beds), available from May. Superb views over the Med. 1hr drive from Nice or Genoa, 15 mins to beaches. Local facilities. £1,200/wk up to 6 people, £1,500/wk more than 6, discounts off season. email: paulauqi@gmail.com; www.holiday-rentals.uk.com/773349
- Moraira, Nr Calpe–Costa Blanca–Spain: Large fully furnished villa. Four beds, two baths, could sleep up to 10. Large pool, garden, patio, peaceful location, five mins to sandy beaches walking distance to restaurants and shops. Close to two golf courses. Family friendly location. Could suit two families. Tel Amanda or Andrew: 01923 816262.
- Nerja, Spain: 1 bed modern apt with balcony (sleeps 4). 100 m from beach. See www.timeabroad.com or call Sharon on 07855 783351.
- Onrust, nr Hermanus, South Africa: Beautiful beach home – 1-hour drive from Cape Town Intl Airport. 5 mins walk from main beach. 5 bedroom house (fully equipped) sleeps 10 people. From £100 per day. Extra flatlet (self contained) sleeping 2-3 available @ £20 per day. Email: lornelf@telkom.net
- Orlando: 2 bed 2 bath new build luxury apartment. Fully furnished. Resort facilities include 24 hr security; 3 pools; kids club/sports; restaurant; spa; gym; sandy beach; golf. 10 mins to all theme parks. Tel: 01268 493266 or email clara_lanre@yahoo.co.uk
- Paphos, Cyprus: Luxury 2 bed apt sleeps 4+ with shared swimming pool. Fully equipped to a high standard, close to tourist amenities, attractions and beaches. Short or long-term lets from £200/week. Tel: +357 26623071 or +357 99300271, email morrisinp@cytanet.com.cy, or www.apartmentsincyprus.co.uk
- Provence: Le Thoronet, beautiful, traditional stone house in middle of vineyards, sleeps 6-8, large private pool and garden. Nice 70 minutes. Tel: 01844 338 145 or email: lorna@lornacemon.demon.co.uk
- Pissouri Bay, Cyprus: 2/3 bed property sleeps 5/6 people. Walking distance to beach and local taverns.
The review of *Good Medical Practice* has involved wide consultation with doctors, patients and the public. The consultation has been undertaken in three main ways:

- open meetings held in five cities across the UK
- written questions about the draft guidance
- research commissioned to examine patients’ views, particularly those from hard-to-reach groups.

The open meetings were reported in detail in *GMCtoday* in December 2005; work is currently in hand to analyse the 500 responses to the written consultation and will be reported in a future edition of *GMCtoday*. The Picker UK research project was completed in January 2006 and will also feed into the review of *Good Medical Practice*. However, the findings of the research are worth considering in their own right.

The study set out to find the views of the public, including some traditionally hard-to-reach groups, as well as doctors on the important elements of good medical care. The report is based on research into the views of a wide range of people, including urban and rural populations, older and minority ethnic and homeless groups.

Dr John Jenkins, Chairman of the GMC’s Standards and Ethics Committee says: “In reviewing *Good Medical Practice*, it was important for us to understand what patients and the public, as well as doctors, thought the right principles and standards were.

We are very interested in the report’s findings, including the broad consensus that the great majority of duties we have included in the new version of *Good Medical Practice* are important, and will consider the full findings as we re-draft our guidance.”

Some of the key findings from the research related to the importance of communication skills. Both the public and doctors agreed that listening to patients as they explained their symptoms and concerns, and explaining a diagnosis and treatment options, played a significant role in the process of making a diagnosis, in helping a patient to understand a condition and in putting a patient at their ease.

The revised draft of *Good Medical Practice* states that there should be a partnership and shared decision-making between doctors and their patients. Doctors and patients see the concept of a partnership as an important and realistic way of working. Most patients felt they should be involved in making informed choices about treatment wherever possible, but many also understood the practical difficulties, including time and resources, that might put restrictions on their involvement.

Good access to and availability of doctors was repeatedly viewed as important, as was continuity of care. The latter was seen as an important way of building up a relationship of trust and confidence with a doctor but also as a way of avoiding lengthy repeats of patient histories.

The study also asked about doctors’ responsibilities outside their clinical practice. Patients didn’t expect their doctors to act like ‘saints’, at least as far as their private life is concerned. They viewed doctors’ behaviour outside the surgery or hospital as largely their own business, provided they did not compromise their professional standards.

Visit [www.gmc-uk.org](http://www.gmc-uk.org) to read the report in full.

We have recently revised our guidance on prescribing medicines. Key changes and additions include:

- a specific requirement that doctors should only prescribe drugs to meet patients’ identified needs
- renewed emphasis on objectivity in prescribing and exceptional circumstances in which doctors might prescribe controlled drugs for themselves or those close to them
- guidance for dispensing doctors, who should not prescribe differently for patients to whom they also dispense for their own financial benefit
- guidance on ‘direction’ – doctors should inform patients about their own and their employers’ interests in pharmacies and should avoid conflicts of interest, which can impede patient choice.

We have sought to promote communication and partnership, which is essential if patients are to get the most out of their medicines. Guidance about repeat dispensing has also been included along with additional advice on prescribing for overseas patients.

All our published guidance is available in our online guidance library:

[www.gmc-uk.org/guidance/library](http://www.gmc-uk.org/guidance/library)
A doctor’s name was erased from the Medical Register after a Fitness to Practise Panel found that his poor knowledge base and consulting skills posed a danger to patients.

The doctor underwent an assessment of the standard of his professional performance before his appearance at the Committee on Professional Performance in 2003. At that time the CPP concluded that the standard of his performance was seriously deficient in a number of areas and gave cause for concern in others and that the doctor lacked insight into his shortcomings. It therefore suspended his registration for 12 months.

At a review hearing in 2004 the Fitness to Practise Panel noted that the doctor had endeavoured to address the deficiencies in his practice. However, it was not satisfied that he was safe to return to unrestricted practice. The doctor was willing to undertake a further objective assessment of his knowledge and skills, and the panel, recognising that this would provide the best objective evidence as to the level of improvement of his medical skills, imposed a further period of suspension for one year pending completion of the assessment.

At the subsequent review hearing the panel considered all of the evidence presented to it, including submissions made by the GMC and the doctor. The panel accepted the contents of the assessment report, which concluded that the doctor did not have the knowledge, consultation skills or practical skills to practise as a general practitioner. The report made plain that his consultation skills were not only unacceptable for general practice but would be unacceptable in any other branch of medicine involving contact with patients.

The panel noted the assessment team’s opinion that the doctor should cease professional practice because he was unable to provide an acceptable standard of care, and that his poor knowledge base and consulting skills posed a danger to patients. The panel was concerned that the doctor’s fitness to practise was seriously deficient in multiple and significant areas of his practice and that there had been no evidence of any improvement between the two assessments. The panel was also concerned by the doctor’s lack of insight into the deficiencies which were evident from the more recent assessment. It was therefore satisfied that his fitness to practise was impaired.

In deciding what action to take against the doctor’s registration, the panel made clear that it had borne in mind that any sanction imposed must be proportionate and protect patients and the wider public interest, that is, the maintenance of public confidence in the profession by upholding proper standards of competence.

The panel noted the supportive letters submitted on the doctor’s behalf and his submission that he had served society for many years as a general practitioner.

It also noted the efforts made by the doctor to engage in various medical activities with colleagues and institutions since the preceding hearing. However, none of these efforts had remedied the deficiencies in the doctor’s consultation skills and basic knowledge. Patients must be able to rely on a minimum standard of competence: the doctor’s skills and knowledge remained well below a level acceptable for a qualified doctor, and his consultation skills had deteriorated since his initial assessment.

In the light of all the evidence, and taking account of the Council’s Indicative Sanctions Guidance, the panel directed that the doctor’s name be erased from the Medical Register. It also directed that his registration be suspended immediately.

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**Figure out this competition**************

There is a doctor’s seven-digit registration number hidden in this issue of GMCtoday, as shown, (but not including!) left. Find and note the seven numbers, IN THE ORDER THEY APPEAR on the pages, answer the two questions below and send us your answers to enter the draw to win a beautiful Cross Century ballpen and pencil engraved with your registered name and GMC number.

1) Whose registration number is this?
Hint: Use the List of Registered Medical Practitioners at www.gmc-uk.org to find out whose number it is.

2) Name one place, suggested in the guidance, where you could display your GMC number.

Rules ➔ This competition is only open to registered medical practitioners.
➔ Entries must be received no later than Wednesday 24 May 2006.
➔ All correct entries will go in the draw to win. The winning entry will be announced in the next issue of GMCtoday.
➔ Entries should be clearly marked 'GMCtoday competition' and can be posted to the editor at the address on page 2 or emailed to gmctoday@gmc-uk.org
➔ Please note your GMC number on your entry.

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Your views matter!

If you wish to share your views about a particular matter, please contact the Editor, Jane Janaway, at: gmctoday@gmc-uk.org

Copy deadline for the June issue is 15 May 2006.