

Chapter 7

General Practice and Care at the End of Life: How Family Practice Changes According to Country



Pierre Mallia

Abstract General Practitioners/family doctors face end of life on a regular basis (Although they may sometimes be considered distinct, the terms Family Doctor (and Family Medicine) and General Practitioner (and General Practice) are commonly used interchangeably. Unless otherwise specified, this is the approach taken in this chapter). Whilst some people have arrangements to die at home and therefore require regular visits by the family doctor, others need the services of GPs to help from the very beginning when a diagnosis of a terminal illness is made. The chapter discusses the work of general practitioners and how they can help families and patients with services and indeed start the process of planning ahead. Post graduate curricula on the topic of end of life are discussed, especially for the case of the UK, and what is expected from a general practitioner. The challenges faced globally and suggestions on how they can be improved is also discussed within the context of home care and the competencies of general practitioners.

Keywords Dying at home · Core competencies · Satisfaction · Primary care management

7.1 Introduction

It is often said those who specialise in a particular medical discipline (such as cardiology or gastroenterology) know more and more about less and less, whilst General Practitioners (GPs) know more and more about more and more. This is particularly true when one considers the increasing range of knowledge that they have to deal with and the broad scope of this speciality in ‘generalism’ ranging as it does from child health to reproductive health to elderly populations. End of life care is one of the areas GPs need to be competent to provide, notwithstanding the fact

P. Mallia (✉)
Medical School, University of Malta, Msida, Malta
e-mail: pierre.mallia@um.edu.mt

that in many developed countries increasing numbers of people are dying in a professional care setting. Ballat and Campling (2013) (p 115) state that in the United Kingdom (UK) most people die do so in a hospital, and usually do so following a chronic illness. Ballat and Campling note that most people would prefer to die at home however, even though in the UK less than 20% do, with a similar proportion dying in care home and few dying in hospices. They quote medical psychoanalyst Anton Obholzer who suggests that the health service is in fact a ‘keep-death-at-bay’ service. Thus, even those who realise they are dying tend to attend hospital as their condition worsens.

The reason for the number of deaths taking place in hospital rather than in the home, is that:

“modern affluent society is particularly uncomfortable with the reality of death, a discomfort that makes it a difficult area for both healthcare staff and patients and their families. Some doctors and nurses feel anxious about engaging in a conversation about death and prefer to avoid it. They adopt a more comfortable, task-centred approach, focussing on the disease process and the technicalities of intervention rather than risk emotional, interpersonal contact. At the same time, some patients and their families find it difficult to face the thought of imminent death and understandable want ‘everything possible’ to be done, reinforcing the pressure on staff to adopt aggressive treatment approaches, however minimal the possibility of ‘cure’” (Ballat and Campling p. 117).

General practice is not confined to one body system or group of patients, although in some countries some do pursue a further specialization so as to provide for the needs of a particular group, such as elderly patients for example. But in general, GPs face most diseases at the primary care (primary contact) level. Whilst death at home was very common in the past, it cannot be said to be negligible today and there are increasing efforts to improve systems. One area of difficulty may be communicating the fact that not all that can be done in hospital can actually be attained at home. But once it is appropriately communicated that a lot that is actually done within hospitals may be futile or extraordinary, and may only serves to prolong a person’s suffering, then the patient may be reassured by the availability of adequate treatment for a comfortable death at home. Thus, people will hopefully and probably opt to die at home, which has the advantages of one’s surroundings and comforts with the added advantage of being close to friends and family.

GPs are specialist physicians trained in the principles of general practice. They are *personal doctors* primarily responsible for the provision of comprehensive and continuing care (Bradley 2006). They also provide care within the context of the family, meaning that they are aware of how the family affects the illness and how the illness affects the family. Therefore, besides promoting health, preventing disease and providing cure and care, they also offer palliation, which includes that which may be required towards the end of life. Moreover, GPs provide a biopsychosocial approach to health care which means that they can look after aspects which in hospital can at best be referred to other specialists within or without the hospital. GPs in the UK, according to one review, find caring for dying patients rewarding both for themselves and the families involved; they have good relations with

community nurses but less satisfactory relationship with the hospital when patients die there (Field 1998). The core competencies of general practitioners are:

1. Primary care management
2. Person-centred care
3. Specific problem solving
4. Comprehensive approach
5. Community orientation
6. Holistic modelling

Whilst it is beyond the scope here to enter into detail of each one of these areas, they are almost self-explanatory. Furthermore, it can be seen that whilst these competencies were defined by the World Organisation of National Councils and Association of family doctors (WONCA), they can illuminate end of life home-care. According to Bradley the competent practitioner implements these tasks in three areas: clinical tasks, communication with patients, and management of the practice (Bradley 2006) (P. 4), giving a contextual, attitudinal and scientific research-based approach. The care provided by family doctors is, moreover, of a continuing type and it is often recommended that people ought to be able to ‘name’ their GP. The caveat however is that in some systems one can have GP practices where care may be provided by a group of doctors. In other systems, such as that found in Malta, one has a dual system – one of which is a true family practice service which is provided by private doctors (on a fee by consultation bases), whilst the other occurs through Health Centres where the doctors provide a walk-in service and also house calls. Whilst the latter is faithful to the core competencies, continuity may be provided through patient files and the patient does not always see the same doctor. In this respect it is argued that ‘family practice’ cannot be applied to this system of general practice. WONCA recognises the differences in many countries that GPs/FDs provide. Some may be more involved in public health or in tropical diseases, others provide some services which in more developed countries may be provided in hospitals. But the concept of primary care and the practice of community-based medicine based on GPs remains.

7.2 Core Competencies at End of Life

Although these are not clearly defined, we here identify them according to specific literature which are relevant on a global level. They can be listed as follows:

- (a) Recognising patients who will die in the near future
- (b) Communication
- (c) Identifying and managing preparatory grief and depression
- (d) Pain management
- (e) Managing common symptoms
- (f) Respecting preferences

(g) Making decisions with families

Recognising the imminence of death (be it within 1 year as defined by the General Medical Council Guidelines on End of Life, UK, and then recognising the imminence of the last few days). GPs can play an important role in timely recognition of death's imminence. A Dutch Sentinel Network of GPs studied how long before death do GPs recognise patients likely to die in the near future? Which patient, illness, and care-related characteristics are related to such recognition? How does recognising death in the near future, before the last week of life, relate to care during this period? (Abashi et al. 2011). Analyses showed that cancer and low functional status were positively associated with recognising death in the near future, and that this in turn was associated with fewer hospital visits, more GP contacts in the last week, more deaths in the preferred place, and more frequent GP-patient discussions about specific topics in the last 7 days of life.

Recognising that death will likely occur in the near future is vital for planning end-of-life care, decision making and allocation of resources. GPs did not identify that death was imminent in one-third of patients who did not die suddenly and it was completely missed in 20% of home deaths. Whilst the authors acknowledge that the dying phase will not always be discernible, these results point to the fact that GPs could use salient triggers in the process of recognition by, for example, assessing palliative care needs systematically.

Emery points out that more than 50% of those with terminal cancer wish to die at home surveys in the UK show that less than 20% do notwithstanding (Emery 2013). He asserts (albeit though a utilitarian analysis of cost) that it is worth studying what the obstacles are to allowing patients at the end of their life, to be cared for, and die at home. Dying at home, he points out, is associated with a 'good death' by many people. Emery identifies three main challenges – Identification of Patients, Improving Communication, and, Improving Training.

The Gold Standards Framework Prognostic Indicators (National Palliative and End of Life Care Partnership 2015; Mahmoud et al. 2008) have been developed to aid identification and it requires questions such as asking oneself whether one would be surprised if the patient had to die within the next few months, weeks, or days. This is followed by identifying cues in the patient. Once identified, communication with patients is essential especially when it comes to the preferred place of death. Improved training has been advocated and many studies show that doctors appreciate this training (Abela and Mallia 2016a, b). The chapter on Palliative Care in this book discusses this area more closely on a global level through studies carried out by the World Health Organisation.

Communication is essential not only to identify the wishes of the patient but also in discussing the advantages and disadvantages and the understanding on the part of the patients and/or family of the moral values of their culture/religion.

Patients need to understand:

1. What is the difference between home care and hospital care? In some countries hospitals may be far away and the care not optimal whilst in others dying patients going through a protocol of taking bloods daily, setting up of drips and other

measure which can verge on the extraordinary. This may be due to the fact that once in hospital people expect more.

2. The services, including the availability of the GP, which are accessible at home – such as hospice movements, local community organisations, etc.
3. The moral implications of these differences; the difference between ordinary and extraordinary care, the moral licitness of providing pain relief even if some perceive it may hasten death, and the legitimacy of these according to the cultural and religious values of the individual and the family
4. The feasibility of staying at home: is there someone at home with the patient at all times, even if to open the door for a community nurse? Etc.

Barclay and Arthur (2008) point out that the patient preferences in the UK for place of death are not stable. Longitudinal and qualitative studies reveal that the preference to remain at home can decline as the illness progresses and as the patient becomes less well they may opt for hospital care. It is unclear, they assert, whether this is due to the patient seeking better care, to save the relatives and friends the burden of them dying at home, or a combination of the two. Certainly the latter has become a cultural problem in Western families. Conversely, to be successful, palliative care has to include the patient's desire to remain at home, their attitude to death and dying, and the impact of the illness in terms of symptom management and the maintenance of personal dignity in the face of increasing weakness (Barclay and Arthur 2008).

7.3 The Global Challenge

In the 'Practice Guidelines' of the *American Family Physician* Smith (2001) lists a number of conditions which ought to be present in providing palliative care and which can be used as a useful guide on a global level. Not all services may be available. Nonetheless one ought to guide oneself to know what can be offered and which are the areas needing improvement. The following is an adaptation/summary of the issues discussed by Smith:

What are the goals of Care?

Care should be coordinated across settings through regular communication during transitions or when needs change

Control of pain and symptoms, psychosocial distress, spiritual issues, practical needs
Preparing patients and families for the process of dying (taking cultural issues into consideration) with the exploration of available options.

Patients and families should receive ongoing information that enables their full understanding of the condition, and the pros and cons of treatment, plus that their values and goals should be elicited.

Care Team: Skills and Support

Members of the care team should be skilled in the care of the patient population to be served.

Effective communication skills

Effective coordination and continuity of care
 Equal access to all patient populations under their jurisdiction
 Knowledge of prognostication, signs and symptoms of imminent death, and the needs of the patient and family before and after death

Specialist-level Skills

Collectively the team should have specialist-level skills in the physical, social, psychological, spiritual, and legal aspects of medical care.
 These include symptom control, management of social and practical needs, understanding comorbidities such as depression, anxiety, delirium, assessment of spiritual and existential issues, and ethical and legal factors of medical decision factors, such as the availability of Advanced Directives, and the more versatile Advanced Care Planning.

Support for the Team

The team needs education and training as well as care for the emotional impact.
 Policies should guide recruitment, screening, training, work practices, and performance
 Ongoing education, supervision, and support
 Regular meetings for review and discussion of the providing palliative care in the community.

Support for the Family

The family should be educated about the process of palliative care and any respite services and be educated and assisted in providing the patient with safe, appropriate comfort measures and psychological support; they may also need backup resources.
 Routine meetings with family members to assess understanding, wishes and address questions.

Referrals

Patients and families should be informed and offered other available services such as hospices, in-patient care, and community services.
 Referral should be made to those services that meet identified social needs and access to care

Treatment

Treatment decisions should be made according to the goals of care, assessing risk and benefit and preferences of patient and family.
 The goal of pain management is safe and timely reduction of pain and symptoms to an acceptable level.
 Include pharmacological and non-pharmacological, and complementary therapies.
 Barriers include addiction in long term care - managed appropriately by stepping up and stepping down accordingly.
 Conversely carers should work with authorities to regulate controlled substances to ensure that drug abuse do not interfere with the care of patients who are in pain (such as the recent controversy over cannabinoids which may be very useful to terminally ill patients who do not tolerate other medications such as morphine).

Care Setting

Safety
 Flexible visits
 In hospices a space of families to visit, rest, eat or prepare meals
 Meeting with palliative care team
 Privacy
 Child care needs

End of Life

- Availability of referrals for those who have not accessed hospice services
- Recognition and communication
- Addressing of concerns, hopes, fear, and expectations
- Support for issues of life completion according to cultural and religious values
- Pastoral care and its facilitation
- Bereavement services

Ethical and Legal Aspects

- The team and GP should be prepared to discuss and answer the complex ethical issues arising with persons with life-threatening illnesses, recognising cultural variations
- Professional advice about wills and guardianship
- Surrogate decision makers should be assisted with ethical and legal advice, such as honouring patient's wishes
- Discuss dilemmas of withholding or withdrawing treatment. Although these are seen to be morally equivalent, people perceive them differently and ought to be addressed accordingly if necessary.

Smith also discusses Care Plans and Quality. Here they are discussed separately below due to their contemporary nature and significance.

7.4 Advanced Care Planning and the General Practitioner

Advanced Care Planning is a process of discussing with the patient, their care providers and often those close to them, the future care of the patient (Kite 2010). It provides a framework for the preferences of the patient. Because Advance Directives are not yet norm in many countries (and indeed having strict legal frameworks can complicate things at the end of life when decisions are wont to be reversed), end of life decisions for patients without medical decision capacity are made regularly with discussions between the patient's physician and the family (LANG, QUILL). Planning ahead for this eventuality is essential. Lang and Quill (2004) argue that the most common pitfalls in establishing plans of care for patients who lack capacity include failure to reach a shared appreciation of the patient's condition and prognosis, a failure to apply the principles of substituted judgement, and offering the choice between care and cure rather than life-prolonging treatment (which can often simply mean referring as an in-patient).

Patients, especially early on in the treatment plan, however, are often able to discuss planning ahead. Family physicians are in a position to integrate medical knowledge, individual values, and cultural influences into end-of-life care; they can best respect the capacity and autonomy of patients by allowing the patient and family to prospectively identify relevant health care preferences by sustaining an ongoing discussion and by abiding by these decisions (Crane and Wittink 2005).

Whilst the chapter in this book by John Paes goes into more detail on Advanced Care Planning, especially in the hospital setting, what applies in the hospital will also apply in the community. The aim of ACP is to fulfil the goals held by many patients, including,

- Participation in decisions about treatment preferences
- Preparation for death
- Achieving a sense of completion
- Being in familiar surroundings in the company of close family and friends. (Kite 2010)

Whilst hospital physicians have a vital role in identifying patients who have reached the last year of life (Kite 2010), communication and coordination with family physicians is important to achieving the goals intended by ACPs. It is important that both primary care and secondary care physicians understand, agree, and document Advanced Decision to Refuse Treatment (ADRT). This is not as easy as one can imagine it to be, but the role played by a GP who will not refer a patient unnecessarily to hospital when the time comes is not only essential but perhaps needs legislation back-up. It is important that primary and secondary care physicians work together to attain this goal both locally and on a global level, respecting human values and the right to be allowed to die without undue intervention. Such can be the case, for example, for a patient with motor neuron disease, who does not wish to live on a respirator, even if this prolongs her life by a few years. Moreover in many countries there is not the possibility of such treatment at home and the person may have to remain until the end in an intensive care unit, or at best in a ward. The GP has the role of finding things out for the patient and act as advocate for her and the family.

ACPs always act in accordance with the law but there are things which the law must clarify, even though they are technically lawful (or not unlawful). It avoids legal showdowns and reassures family and friends in the mourning process that no decision which verges on euthanasia in the mind of people, for example, has taken place. Protocols and published standards of care are important to satisfy that health care providers have not been negligent.

7.4.1 Patient Advocacy

Primary care physicians are numerous enough and strategically placed to identify areas which need improvement. Both alone and together they can act, as the case may be, as patient advocates to improve protocols, standards, ethical documents and encourage legislations in this regard. The local Colleges and Associations of GPs can work with other Physician and health care professions' associations to effect change. A clear example is the case of the preceding paragraph where legislation or standards would be helpful when deciding about refusing life prolonging treatment and making the final decision not to refer to hospital when the time comes and be prepared for any sedation of distress.

7.4.2 *Quality Framework*

Countries ought to strive to have quality frameworks for proper end-of-life care and palliative care. Implementing pathways with due training and communication, for example, can give rise to distorted perceptions, as happened with the Liverpool Care Pathways. In point of fact, the lack of training and not following the 'path' may have made these perceptions right in some instances, as many British authors pointed out retrospectively.

Quality frameworks are important to link scholarship with action (Tan 2007). GPs strive to maintain continuity of care within an increasingly complex health care environment. GP recognise that they work and live in a highly complex world and not a purely mechanical one, and that the unique perspective and experiential knowledge that resides in each family physician in their individual setting provides the basis for therapeutic management at various levels. Of the health care environment (Tan 2007). Quality Improvement (QI) is a priority in health care. New research redefines best practice and health needs in particular populations, such as the elderly, changes (Booth and Snowdon 2007). Moreover, health needs in different countries change and this points towards important QI programme which needs to be adapted locally.

As principal coordinators of end of life care for people dying at home, such frameworks can highlight achievements and gaps (Booth and Snowdon 2007). In health care QI occurs through Vocational Training programme which lead to the specialist qualification of GPs, Fellowships of Colleges, Continuing Medical Education and Continuing Professional Development (such as taking a course in palliative care or communication skills) are the mainstay of QI in general practice.

However there are other stake holders in end-of-life care, including nurses, other health care professionals, patient groups, legislators, hospice movements etc. and last but not least the politicians who is entrusted with effecting change. Broad consultation is needed to improve quality of care. On the other hand one must assess the capacity of local General Practice services to handle end of life care. Capacity has to be assessed both at national level and on a personal (capacity) level – the GP self care (Snowdon et al. 2007). 'What is our capacity to provide end-of-life care at home?', for example, needs to be answered effectively for the system to work – acceding better to patient's wishes, and in the process allocating resources more effectively. The professions own uncertainty for the need for change can offer resistance (Flynn et al. 2007). A vision has to ensure, besides the capacity, the doctors are properly qualified and fit to practice, promote excellence and good practice, responds to concerns of the individual and works with the community and medical profession to identify and resolve problem areas (Flynn et al. 2007). The involvement of community ensure patient-centred responses, expectation of consumers, and health inequalities (Booth and Snowdon 2007).

Quality means that one has to focus on competence at all levels, from that of individual health professionals, to working as a team (Atkinson et al. 2007). They need clear and concise templates or pathways, training in these pathways, clear

defining of the roles within the team, with regular face-to-face meetings and regular professional development.

In the UK, the ‘Gold Standards Framework’ for end of life care showed that its implementation enabled process of communication and that it was associated with a marked high quality palliative care in general practice, although there was a marked variation in how this worked in individual teams; but the general hierarchical doctor-nurse relationships persisted (Mahmoud et al. 2008).

7.4.3 Multidisciplinary Teams

GPs are an essential factor in a community multidisciplinary approach to end of life care, but one should not undermine the important role of other professionals with whom the patient and family also create relationship, without whom the GP cannot function effectively. Mahmoud Yousef et al. assert that multidisciplinary working in primary care is essential for delivering high quality end-of-life care in the community. Implementing can take time and in the UK the hierarchy remained. District nurses and GPs are shown to have different priorities and styles of multidisciplinary workings. Teams who have a relatively non-hierarchical working style rather than a rigidly hierarchical structure of decision making seem to be more effective. High performance practices displayed a clear shared purpose among staff for palliative care. Effective primary care therefor appears to require good team work. The Gold Standards Framework has helped in this regard when implanted, in providing the elements of the seven-Cs – communication, coordination of care, control of symptoms, continuity out of hours, continued learning, carer support, and care in the dying phase.

7.5 Knowledge and Skills Required of GPs at the End of Life

Acknowledging the contextuality of primary care and general practice, with special regard to end of life issues, considering the divergence of global issues ranging from lack of resources, distance from services, lack of clean water, etc., the Curriculum of the Royal College of General Practitioners (REF) is a good guide in this regard. It states that:

- An essential role of a GP is to help patients die with dignity, providing individualised care and minimising distress
- Many terminally ill patients prefer the option of a death at home
- Most patients die of non-cancer/co-morbidity in old age
- GPs must be able to identify patients in the last year(s) of life and their carers
- GPs must be able to assess patients holistically and compassionately and agree personalised plans for their future care

Team working, interagency working and communication are fundamental to good end-of-life care

Curriculum of the Royal College of General Practitioners, Chapter 3.09 End-of-Life Care.

Knowledge and skills guide (3.09 End-of-Life Care RCGP Curriculum: Professional and Clinical Modules 18 May 2015 p 183).

Core Competence: Fitness to practise

This concerns the development of professional values, behaviours and personal resilience and preparation for career-long development and revalidation. It includes having insight into when your own performance, conduct or health might put patients at risk, as well as taking action to protect patients.

This means that as a GP you should:

- *Read the GMC's document on end-of-life care with case examples*
- *Recognise that personal life events, such as deaths in the family, can make full clinical engagement a test of your professionalism*

Core Competence: Maintaining an ethical approach

This addresses the importance of practising ethically, with integrity and a respect for diversity.

This means that as a GP you should:

- *Be aware of your cultural values and/or religious beliefs which might make it difficult for you to be non-judgemental about your patients' decisions at the end of their life*

Core Competence: Communication and consultation

This is about communication with patients, the use of recognised consultation techniques, establishing patient partnership, managing challenging consultations, third-party consulting and the use of interpreters.

This means that as a GP you should:

- *Communicate effectively with the patient, their family and carer(s) regarding difficult information about disease progression and prognosis.*
- *Describe how to provide and manage 24-h continuity of care through various clinical systems*

Core Competence: Data gathering and interpretation

This is about interpreting the patient's narrative, clinical record and biographical data. It also concerns the use of investigations and examination findings, plus the adoption of a proficient approach to clinical examination and procedural skills.

This means that as a GP you should:

- *Describe palliative care emergencies and their appropriate management:*
 - *use of emergency drugs*
 - *major haemorrhage*
 - *spinal cord compression*
 - *anxiety/panic o dysphagia*
 - *bone fractures*
 - *hypercalcaemia*
 - *superior vena cava obstruction*
- Core Competence: Making decisions*

This is about having a conscious, structured approach to decision-making; within the consultation and in wider areas of practice.

This means that as a GP you should:

- *Apply best practice principles for end-of-life care in community settings, such as those described in the Gold Standards Framework*
 - *Counsel and explain for patients, families and their carers:*
 - *a holistic and personalised assessment of needs*
 - *symptom control*
 - *disease progression*
 - *processes around death and dying*
 - *advance care planning o normal and abnormal bereavement*
- Core Competence: Clinical management*

This concerns the recognition and management of common medical conditions encountered in generalist medical care. It includes safe prescribing and medicines management approaches.

This means that as a GP you should:

- *Co-develop with the patient, carers and family an effective plan to manage the full range of their physical, psychological, socioeconomic, cultural and spiritual needs*
- *Manage distressing symptoms, e.g. nausea, pain, shortness of breath and confusion.*
- *Use appropriate drug/nutrition delivery systems, e.g. a syringe driver*
- *Prescribe effective drugs and suitable combinations of drugs, pre-empting likely side-effects*
- *Describe the conversion of drugs from oral dosage to other appropriate delivery systems*

Core Competence: Managing medical complexity

This is about aspects of care beyond managing straightforward problems. It includes multiprofessional management of co-morbidity and poly-pharmacy, as well as uncertainty and risk. It also covers appropriate referral, planning and organising complex care, promoting recovery and rehabilitation.

This means that as a GP you should:

- *Summarise the principles of palliative care and end-of-life care and how these apply to cancer and non-cancer illnesses such as cardiovascular, neurological, respiratory and infectious diseases*

Core Competence: Working with colleagues and in teams

This is about working effectively with other professionals to ensure good patient care. It includes sharing information with colleagues, effective service navigation, use of team skill mix, applying leadership, management and team-working skills in real-life practice, and demonstrating flexibility with regard to career development.

This means that as a GP you should:

- *Function as both leader and member of end-of-life teams, as required*
- *Work effectively with the community nursing and end-of-life care teams and teams from social care and voluntary sector organisations*

Core Competence: Maintaining performance, learning and teaching

This area is about maintaining performance and effective CPD for oneself and others, self-directed adult learning, leading clinical care and service development, participating in commissioning, quality improvement and research activity.

This means that as a GP you should:

- *Understand the evidence base for care at the end of life, while also acknowledging that it is less rigorous because there are very few trials available.*
- *Understand the difficulty of running double-blinded randomised controlled trials in patients who are dying.*

Core Competence: Organisational management and leadership

This is about the understanding of organisations and systems, the appropriate use of administration systems, effective record keeping and utilisation of IT for the benefit of patient care. It also includes structured care planning, using new technologies to access and deliver care and developing relevant business and financial management skills.

This means that as a GP you should:

- *Review the key national guidelines and policies that influence healthcare provision for end-of-life and palliative care, applying these compassionately to the personalised needs and wishes of patients, their families and carers*

Core Competence: Practising holistically and promoting health

This is about the physical, psychological, socioeconomic and cultural dimensions of health. It includes considering feelings as well as thoughts, encouraging health improvement, preventative medicine, self-management and care planning with patients and carers.

This means that as a GP you should:

- *Identify and respond to the spiritual, socioeconomic and cultural needs of the patient, family and carers, in addition to their 'biomedical' physical and psychological needs*
- *Acknowledge the appropriate use of alternative therapies which individual patients may find provide comfort, while bearing in mind the evidence for their use*
- *Recognise normal and abnormal grieving, and its impact upon symptomatology, and provide support appropriately*

Core Competence: Community orientation

This is about involvement in the health of the local population. It includes understanding the need to build community engagement and resilience, family and community-based interventions, as well as the global and multi-cultural aspects of delivering evidence-based, sustainable healthcare.

This means that as a GP you should:

- *Summarise the social benefits and services available to patients and carer(s)*
- *Describe the current population trends in the prevalence of terminal illness in the community*
- *Explain the importance of the social and psychological impact of terminal illness and dying on the patient's community, such as their wider family, friends, dependents, employers and work colleagues.*

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