EUROPEAN *in*sight

In this new section, European palliative care organisations are invited to explain their goals, express their hopes and voice their concerns

APM: still much to be done to improve the delivery of care in the UK

The Association for Palliative Medicine of Great Britain and Ireland (APM) was founded 22 years ago and the UK medical specialty of palliative medicine is now 21 years old. This year, the APM published a strategy to take stock of our progress and to plan our activity in the years to come. I have reproduced some of the document in this article and included the summary that encapsulates our ideas.

Bill Noble, APM Chairman

What began as the vision of a few passionate individuals, with ideas that had origins in France and Ireland, is now firmly established at the heart of our health services. Over the years, we have debated definitions, referral criteria and outcomes, while steadily deepening and broadening the reach of palliative care. We have brought the benefits of rational therapeutics and modern pharmacology to many patients in great distress. This was achieved with the collaboration of our colleagues in nursing and other disciplines, the support of local communities and resources of many voluntary sector organisations. Latterly, the tenets of palliative care have entered undergraduate medical curricula, postgraduate training programmes and mainstream health service policy relating to end-of-life care.

As readers of the *European Journal of Palliative Care* may know, the benefits of longevity are always accompanied by a few difficulties. The politics of the early hospice movement in the UK left us with organisational structures that we would not necessarily choose if we were starting again. I was privileged to be introduced to hospice medicine in Sheffield in the early 1980s and my view is perhaps coloured by that perspective, as well as the influence of my teacher, Professor Eric Wilkes. He was one of the first UK hospice founders whose skill at bringing together influential supporters gave palliative care in the UK a flying start. His vision was of palliative care wholly integrated with every part of the health service. As an academic GP, he saw no reason why every doctor could not do what he did for the dying. I agreed with him then; now I think that it was the rigorous approach of senior colleagues to building a specialty that has allowed us to make a full contribution to our system of healthcare.

That was the time of hospice building in the UK, and palliative care was firmly established as an activity driven by small independent organisations, funded by local benefactors or public campaigns, outside the bureaucratic constraints of the National Health Service. Doctors working in hospices needed an organisation to help them exchange ideas and benchmark practice, so it was agreed to form an association only for medically qualified members. In my view, there were two consequences of that decision, one good and one not so good. First, we were able to concentrate on developing a medical specialty and integrating palliative medicine with the Royal College of Physicians' structures, enabling most of us to hold NHS contracts and take our place beside

colleagues in hospital practice. Second, however, we were seen as a sectional interest within palliative care and the hospice movement, so we lost opportunities to influence policy at a national level as a professional body.

In spite of palliative medicine's relatively unfamiliar name, public and institutional expectations of our members have increased to the point where failure to deliver equitable, safe and effective care is unacceptable. The ability to practise in a variety of care settings, with mixed funding streams, is increasingly important – along with the willingness to engage with patients whose distress has origins in a wide variety of pathology. Clinical methods of palliative medicine physicians have evolved and benefited from the experience of doctors from many different backgrounds. We have defined a set of skills that distinguish members of our specialty as well as a body of knowledge that is essential to practise modern palliative medicine. While our collective voice may have been quiet, the contribution of some individuals within our discipline has been remarkable, and at least partly responsible for the progress on health policy that we are witnessing now.

We recognise that there is still much to be done to improve the delivery of care, as well as the effectiveness of our interventions. As a specialty at the heart of palliative care services, we have argued for equity of access as well as efficient use of resources. While most medical interventions in the context of palliative care yield important benefits for many patients, there remain a number of individuals whose distress is refractory to most orthodox practice in the specialty. It is important

Palliative medicine in supportive, palliative and end of life care: APM strategy for 2008 to 2010

Executive summary

The purpose and scope of this strategy

This document represents a consensus within the Association for Palliative Medicine of Great Britain and Ireland (APM), relating to important issues in palliative medicine. It takes account of health service policy developments and is intended to inform members of the APM, our colleagues, partner organisations and policy makers. A substantial consultation has preceded it, including a survey of members' views, debate at a meeting of APM officers and two annual general meetings, circulation of a draft strategy and a final round of correspondence.

National policy developments

NHS policy since 2004 has ranged from improving supportive and palliative care in cancer services to making palliative care available to patients with many diverse advanced conditions. Systematic, high quality, end of life care in every setting, with enhanced choice for all patients is a clear policy goal in 2008, along with supportive care for surviving cancer patients.

Matters of concern

There is a need to define the scope and role of the specialty of palliative medicine in relation to important policy developments and to strengthen our influence for rational, equitable, efficient, patient-centred care. We wish to make further progress in the relief of patients' distress by enhancing scientific activity. We need to share our experience with colleagues within and beyond the specialty and collaborate more effectively in improving practice, research and training. The Association should inform public debate on ethical and policy issues.

for us to recognise the deficiencies in our therapeutic toolkit as well as some of the barriers to accessing our services. Although the plight of carers is recognised as part of our responsibility, interventions in the care of families, carers and the bereaved also remain inadequate.

It is fair to say that, in recent years, UK palliative medicine physicians have not been as vocal or as influential as they were in the past. At a time when non-clinical palliative care research has thrived in the UK, clinical researchers have struggled to make a significant contribution. UK health service research is very healthy, as is research focusing on qualitative data gathering and patients' or carers' experience. We have some basic biomedical research findings that need translational research and clinical trials to take us forward. We need to find the resources to do it.

After 22 years of gradual development and careful integration of the principles of palliative medicine, the APM is ready to contribute to supportive, palliative and end-of-life care with a new clarity of purpose. The Association intends to ensure that its members are in the best position to meet the needs of patients and their carers at a time when health policy offers many opportunities to further its aims. We look forward to working closely with our colleagues in medicine and other professions, throughout the United Kingdom and the Republic of Ireland, and to enhancing our links beyond our borders. I am particularly pleased that the European Association for Palliative Care (EAPC) Research Forum will come to Glasgow in 2010, but I hope to explore some new ways of collaborating with colleagues in the rest of Europe before then.

Bill Noble, APM Chairman, 1 October 2008

The role of the doctor in palliative care

All doctors, whether general practitioners or specialists in any setting, hold clinical responsibility for the treatment of their patients and have a role in providing medical leadership in their patients' palliative care.

The role of the palliative medicine physician

The core role of the palliative medicine physician may be defined as the medical assessment of distress, symptom-management and end of life care for patients with complex clinical needs due to advanced, progressive or life threatening disease. They provide medical leadership within palliative care services, hold clinical responsibility for the treatment of patients and act as a specialist resource. Other responsibilities include ensuring quality, efficiency and equitable access to services, advising on strategic planning including commissioning, and developing strategies for research, education and training in relation to palliative care.

The role of the APM

The Association's interest is to support and promote the practice of palliative medicine by specialists and generalists for the benefit of patients and their carers. The Association's role is to foster expertise, effectiveness and excellence among members in their professional roles. The APM does not have party political or religious affiliations and will cooperate with any group, providing that it shares our interests and is acceptable to the membership.

Strategic priorities for 2008, 2009 and 2010

The Association will take a strategic approach to planning our activity for the coming years. We will engage with partner organisations and governmental bodies to play a full part in the development and implementation of policy relating to supportive, palliative and end of life care. The Association will endeavour to promote scientific activity and share innovative practice. Continuing involvement of the membership requires enhanced communication within the Association with the facilitation of special interest groups and working parties. We will devote resources to workforce planning, as well as continuing the development of education and training. Through these activities we will seek a closer engagement with the public and the wider health care community at all levels, at home and abroad.