

Delivering a dignified death in a challenged national health system

Welcome to a New Year and a new look *Clinical Medicine*. As I write this in the first few days of 2018 the struggles of the NHS are writ large in the national media: the wrong flu vaccine, the battleground medicine being performed in corridors of overstretched hospitals, and deferred operations for anyone expecting routine surgery in January. So, as predicted, the NHS is under significant pressure. As general physicians we, alongside our emergency medicine colleagues, tend to bear the brunt of these periods of sustained demand, and, as eloquently expressed by many senior doctors on the national news over the last few days, patients appear to be sicker and frailer than ever before, meaning that many of our initiatives to keep people out of hospital are not as effective as had been hoped. A combination of these factors means that many more frail and elderly patients will be admitted to our acute medical wards and a not-insignificant proportion will die following admission. So against this backdrop, in addition to the usual CME, original research and educational offerings, and as a response to a challenge from the president of the RCP to highlight big issues across all our publications in our 500th year, I wanted to focus a spotlight on improving the quality of end-of-life care.

One of the greatest challenges as a clinician is how to facilitate a good death in a challenged healthcare system. I do not refer to the optimal management of the underlying pathology, but maintenance of care and compassion for those who do not need more acute medical input. The same quality of care is required to support and care for the patient, their family and indeed occasionally their wider network.

To that end, I have commissioned a series of articles across *Clinical Medicine*, *Future Healthcare Journal* and the *RCP Commentary* to explore the clinical, non-clinical and personal aspects of optimising death. This is a challenging subject encompassing moral and ethical, legal,¹ religious,² scientific medical³ and managerial domains that spans primary, social and

secondary care.⁴ I hope we achieve, in some small measure, a positive focus on this important aspect of our professional care.

It is apt that this edition combines CME in acute medicine, a specific look at the strengths and limitations of the NEWS score in acute injury⁵ (which is particularly timely as the revised NEWS has just been released)⁶ and a focus on many issues that affect the elderly. I hope this combination offers practical and helpful education and thought-provoking articles across the whole spectrum of care we deliver, both in the acute life-saving domain and at the end of life. ■

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