# From the Editor

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## 'The ceaseless pursuit of triumph over death in life'[1]

A dying person was once an integral part of the community and, before the advent of scientific medicine, physicians considered the care of the dying to be one of their major roles. Since those days, radical changes in the practice of medicine and in social mores have created many obstacles to helping patients to a dignified death.

Modern advances through the last two centuries increasingly focused on new techniques which yielded spectacular improvements in the prognosis for many diseases, and a huge increase in lifespan. At the same time, people became frustrated when modern medicine failed to avert death, and during the twentieth century discussion of dying became one of the great taboos of the era. That has changed during the last quarter of a century, and the late David Pyke, writing of his own terminal illness, commented that he used to 'try to conceal the diagnosis from my patients, but now I think that was wrong'.[2]

Yet, while modern medicine brought great benefit to mankind, it also introduced powerful tools of resuscitation (reviewed recently by Professor Douglas Chamberlain in his Fitzpatrick Lecture),[3] together with mechanisms for sustaining life by artificial feeding. These are marvellous when used appropriately but can also deny patients a dignified death when used inappropriately or not withdrawn after becoming clearly futile. Doctors, patients and their families are often unable to accept the inevitability of death and with it the futility of resuscitation attempts.[4]

In clinical practice it is therefore crucial to establish when a patient is dying. Hippocrates described the 'facies' bearing his name as portending imminent death, and in recent years Professor Roger Higgs has introduced the important concept of making a diagnosis of dying.[5] That is not always easy and some recently published guidance on specific criteria is welcome.[6] The perception of the patient then changes: their needs are no longer for a cure, and their management can be organised to achieve a death with dignity. In this issue, Dr Polly Edmonds takes this one stage further by describing the introduction of an 'integrated pathway for dying patients' which sets out the specific needs of the dying,[7] resulting in appropriate management of the process of dying. The need for nutrition and hydration is then for alleviation of symptoms, not for sustaining life, and its withdrawal,[8] using guidelines such as those of the British Medical Association and the General Medical Council,[9] become part of the 'integrated pathway'. It is a pity that some pro-life groups fail to understand this process and continue to regard appropriate withdrawal of nutrition and hydration as a prelude to euthanasia, which it is not, and thereby tend to obstruct the process of dying with dignity.

There are still many difficulties in our attempts to care for the dying, highlighted in two articles published in this issue. Dr Polly Edmonds observes that half of all deaths in the UK take place in hospital, yet care of dying patients may be of poor quality.[7] Above all, there are still failures in communication and symptom control. Dr Ilora Finlay reminds us of the problems resulting from lack of privacy and overcrowding in our acute hospitals, exacerbated by pressures on bed usage.[10] She decries the increasing decline in continuity of care, both by general practitioners as a result of large rotas now established, and in hospitals resulting from restructuring of training programmes by postgraduate deans. Adding to these problems are the progressive shortening of working hours and increasing use of shift working required by the European Working Time Directive,

which one hopes may be postponed until there are sufficient numbers of doctors to provide safe cover for patients. The College has indicated the importance it attaches to the subject of trying to achieve continuity of care using existing resources by setting up a working party to examine the issues; its deliberations should be reported during the coming year.

Unfortunately, multiple obstacles to dying with dignity remain: there is, as Dr Finlay observes, a long way to go.

## References


1 Quotation from a talk by Plumb JH, cited in Hawkins C (ed) *The Medical Pilgrims.* London: Royal College of Physicians, 1997.
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6 Ellershaw J, Ward C. Care of the dying patient: the last hours or days of life. *BMJ* 2003;**326**:30–4.
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8 McIlmoyle J, Vernon MJ. Artificial nutrition and hydration: science, ethics and law. *Clin Med* 2003;**3**:176–8.
9 General Medical Council and British Medical Association. *Withholding and withdrawing life prolonging treatments: good practice in decision making.* London: GMC, 2002.
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