

## How are we serving those patients that are reaching the end of their life?

End-of-life care (EOLC) is a difficult topic for doctors and for society as a whole. As physicians, we have been trained to focus on providing safe and high-quality care to our patients, and have been extremely successful at it. There is, however, an inevitability about death which we do not always recognise, in our quest to provide high-quality treatments.

The NHS has contributed to an extraordinary improvement in healthcare in the UK, providing care for all which is free at the point of delivery, and we are rightly proud of this. We have raised our expectations of the age at which death is inevitable year on year, and are living longer than ever before, but how are we serving those patients that are reaching the end of their life?

The suite of articles in this issue of *Clinical Medicine*, together with articles in the latest issues of the RCP's *Future Healthcare Journal* and *Commentary* magazine, explore this topic.

Although death is inevitable for all of us, we are less familiar with it as a society, and cope with it less well than previous generations. My recent experience of the death of near relatives has given me cause to reflect on how difficult this is. There was a period of time in each individual when we all knew that death was very likely, but, even so, the family, and the doctors and nurses did not take the opportunity to discuss it, and to plan for a good death.

Several questions need to be explored by physicians and society together, in order to reach a shared view of how to approach the dying patient, and how to support the patient, family and friends at this difficult time.

It is clear that a large part of our role is to provide pain relief<sup>1</sup> and to manage symptoms,<sup>2</sup> and our palliative care colleagues have helped us to do this better. We understand that many patients wish to die at home; however, in many cases, our community services struggle to provide the level of support required. This is illustrated in the heartrending piece written by the carer of a patient dying of lung cancer, which is published in the current issue of *Commentary*. Although there are examples of good practice, as described by Catherine Waight and Bill Noble,<sup>3</sup> this is not universal.

We still struggle to recognise and acknowledge when people are entering the last few days of life, have difficulty with shared decision making, and wonder what to do about assisted hydration. We tend to carry on until the end, rather than work with colleagues to provide appropriate levels of compassionate care, which take into account a patient's background, or their spiritual needs.

As doctors, we have guidance from the GMC, and legal responsibilities, which are sometimes difficult to interpret, related to mental capacity, or informed consent, which make clinical decision making even more fraught around the time of death in some patients.<sup>4</sup> We also have to consider the increasing debate on assisted dying. At the moment, the majority view of the RCP fellowship is still against assisted dying, but opposition has reduced.<sup>5</sup>

Providing excellent care at the end of life is a crucial part of being a doctor, and one of a number of difficult dilemmas that have not been aired openly enough in medical education or in clinical practice.

As you would expect, the RCP has been at the centre of national debate on these issues for many years, undertaking the End of Life Care Audit<sup>6</sup> and, as part of the Leadership Alliance for the Care of Dying People that produced *One chance to get it right*,<sup>7</sup> a vision for improving care at the end of life. Continuing this involvement, as part of our programme of work in 2018, the RCP is providing a focus for discussion on the difficult dilemmas that current physicians face. This project is called Our Future Health. We will be discussing difficult issues with fellows and members and I am keen that we physicians lead the debate, using our wealth of clinical and healthcare experience to contribute patient-centred, pragmatic and evidence-based dialogue. What do we think about quality versus longevity of life in the current clinical landscape? How can we ensure that appropriate use of resources, patient experience and health outcomes do not become mutually exclusive? Over the last few decades, although life expectancy has significantly increased, so too have the number of years with which people are living with chronic health conditions which impact quality of life. Where should we focus? Is it improving quality of life, patient experience, patient safety, health outcomes, length of life or population health?

Whatever your view, shouldn't we use our experience as physicians to make sure we provide the highest possible quality of care to all of our patients, and to provide the same high-quality compassionate care for those who are at the end of their life? We need to lead the debate. ■

### References

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- 3 Waight C, Noble B. Dying at home the Midhurst way. *Future Healthcare Journal* 2018;5:7–9.
- 4 Wills C. Legal and practical issues at the end of life. *Clin Med* 2018;18:32–4.
- 5 Porter K, Warburton K. Physicians' views on current legislation around euthanasia and assisted suicide: results of surveys commissioned by the Royal College of Physicians. *Future Healthcare Journal* 2018;5:30–4.
- 6 Royal College of Physicians. *End of Life Care Audit – Dying in Hospital: National report for England 2016*. RCP, 2016.
- 7 Department of Health. *One chance to get it right*. DH, 2014.

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