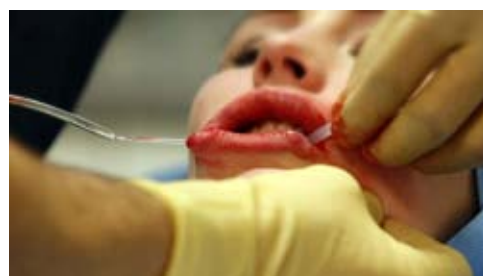




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Refresh yourself.

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PICTURE OF THE WEEK

Thousands of demonstrators filled Stafford's town centre on Saturday 20 April in support of Stafford Hospital, which faces cuts in services after Mid Staffordshire NHS Foundation Trust was put into administration (*BMJ* 2013;346:f2444). The trust first made the headlines when a Healthcare Commission investigation sparked by high death rates uncovered "appalling" care at the hospital between 2005 and 2008. Administrators have already partly closed the hospital's emergency department, and further cuts to services may follow.

RESPONSE OF THE WEEK

The modern NHS is not isolated in suffering from some moral affliction, but rather reflects the prevailing society from which it draws its workers and its patients.

The failure of nurses and doctors to demonstrate compassion or to simply spend time with patients and families is mirrored by patients and relatives who feel it's ok to lie or be abusive or manipulative to get what they want. It's two sides of the same coin.

Our individualistic culture values personal ambition over duty and service, and naturally ends in narcissism. Perhaps a sense of our connectedness and interdependence would only return with a crisis of poverty or war or with a religious revival. Perhaps we need to learn again what it is to wash our fellow man's feet.

Ross A Kirkbride, GP trainee, Birmingham, UK, in response to "The NHS could learn much from Gandhi's teaching" (*BMJ* 2013;346:f2411)

MOST SHARED

Doctor who lied on his CV is allowed to return to work
 Reducing sodium and increasing potassium intake
 Vitamin D sufficiency in pregnancy
 Liverpool care pathway is a nice idea—pity about the practice
 What should clinical commissioning groups do on 1 April 2013?

BMJ.COM POLL

Last week's poll asked: "Can we leave industry to lead efforts to improve population health?"

89% voted no
 (total 666 votes cast)

This week's poll asks:

"Do patients need to know they are terminally ill?"

Head to Head:

Yes ☒ *BMJ* 2013;346:f2589

No ☒ *BMJ* 2013;346:f2560

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EDITOR'S CHOICE

Helping patients to die well

While modern medicine often seems to actively promote bad end of life care, doctors can do a great deal to help patients achieve a good death

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There is more than one way to die well, say Katherine Sleeman and Emily Collis in their article on caring for dying patients (p 33). The trouble is that far too many people die badly. Whatever your definition of a good death, dying in hospital when you would prefer to die at home, or dying in pain, distress, isolation, or uncertainty will not be part of it. Yet, as the authors explain, over half of all deaths (in the UK at least) occur in hospital, many patients die with unmet needs, and more than half of complaints referred to the Healthcare Commission are about the care of dying people. All of this is despite the growing recognition of the need for good end of life care. And of course the risk of dying badly matters not only to the person who is dying but to their relatives and friends. The authors quote Cicely Saunders, founder of the hospice movement: “how we die remains in the memory of those who live on.”

But there is good news. While modern medicine often seems to actively promote bad end of life care, doctors can do a great deal to help patients achieve a good death. Early identification of the dying phase, good communication with patients and relatives, sensible prescribing, effective management of physical symptoms, and understanding of the patient's social, psychological, and spiritual needs must all play their part.

Sleeman and Collis have targeted their advice towards doctors in training. But clinicians at all levels of experience will benefit from reading their article. Senior doctors will, in any case, want to model the highest professionalism and humanity when dealing with dying patients. Knowing that younger doctors will be taking

their cues from you provides an additional incentive.

The article usefully tackles some of the misconceptions that have dogged the Liverpool care pathway in recent months. The pathway is a framework, not a treatment, so doesn't need formal consent, but the decision to start someone on it should be made by a multidisciplinary team and should be discussed with the patient where appropriate and always with the relatives. While on the pathway, patients should be supported to eat and drink; and if the patient's condition improves, the pathway can be stopped.

Essential to good end of life care is the ability to recognise that a person is dying. Sadly, this is a prognostic skill that doctors are “notoriously poor at,” say the authors. But do patients need to know that they are terminally ill in order to receive good care? The same authors take part in our Head to Head debate this week, arguing that patients should be told, since this knowledge is necessary for informed decisions (p 20). But Leslie Blackwell argues against what she calls “prognostic disclosure”. This is, she says, “a failed model for medical decision making that creates more suffering than it relieves,” and “for most people the apparent choice between comfort and prolongation of life is a false one.” I'm not convinced, but I would like to hear your views.

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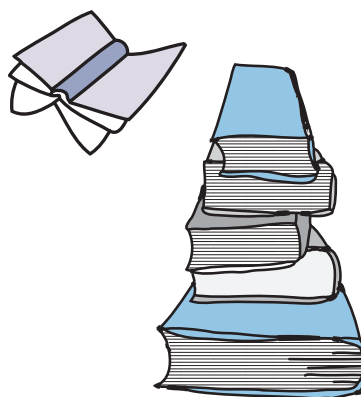
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