**End-of-life care: the neglected core business of medicine**

■ ***The Lancet***

Last week, a report into care of patients at the end of their lives drew attention to the lack of appropriate training in this area given to many doctors. Despite several reports and guidelines over the past few years on the importance of managing end-of-life care, knowledge and confidence among hospital doctors is still far from ideal when looking after those in the last few days, weeks, months, or even years of their lives. With "*Improving end-of-life care: professional development for physicians"*, the Royal College of Physicians (RCP) in the UK hopes to support hospital doctors in caring for people nearing death.

A quarter of a million people die in hospitals in England every year, which is more than the combined total of those who die at home, in care homes, or in hospices. Many people who die in hospital do so under the care of doctors of all specialties, and may never receive the expert help of a palliative care team.

Improving the quality of end-of-life care begins with recognition that the patient has reached the last phase of life, and acceptance by all (patient, carers, and medical staff) that supportive or palliative care is now the only option. In many cultures, this stage is never reached, often because of fear or non-acceptance of talking about death. Initiating conversations about death seems to be particularly difficult for doctors caring for those with non-malignant diseases. In general, open discussion with patients frequently does not happen until the last days of life, leading to most people dying in the acute hospital environment. Doctors must remember that while a few patients might choose to die on an acute medical ward, and sometimes it is unavoidable or unpredictable, most would choose to die in their familiar, and comforting, home.

Identifying those patients in the end-of-life phase is only part of the problem. The RCP's report recommends that undergraduate and postgraduate curricula review their provision for training in end-of-life care principles and techniques. Commissioners and hospital trusts, too, need to support end-of-life care training in their professional development plans, and build appropriate metrics into their care delivery. Reflection and learning about end-of life care should be part of daily clinical practice through multidisciplinary or morbidity and mortality meetings, joint learning with general practitioners, and seeking feedback from patients and carers. The report emphasises the role that palliative care specialists can have in leading, and teaching, specialists in other clinical areas (through joint ward rounds and outpatient clinics, for example), and details the need for regular training for all physicians in current thinking in end-of-life care.

High priority should be given to development of devices that improve the quality of life in those with terminal illness. For example, drainage of ascites at home is now possible with a peritoneal catheter system, which enables management of ascites at home rather than needing paracentesis in hospital, which often necessitates admission for one or two days. The UK National Institute for Health and Clinical Excellence has now approved home use of such a peritoneal catheter system. Widespread adoption of such devices could enable many more patients to receive palliative care at home, protected from the unnecessary burden and inconvenience of a hospital admission.

Above all, it takes courage to tell people the truth about their prognosis, and to begin the conversation about where and how they see their remaining time best spent. Continuing that conversation involves skill and knowledge, which can be improved through teaching and experience. Encouraging people to write advance directives should be part of those conversations. Palliative care teams are highly knowledgeable and skilled in talking to patients about dying, but that expertise needs to be shared, at least in part, with all doctors working in hospitals and with those in the community.

Most people, if asked, say they would rather die at home than in hospital. Having more time at home is another wish frequently expressed by people in the last phase of their lives; asking for more time in hospital is rare. Yet the instincts of doctors to prolong life, and perhaps their fear of accusations of therapeutic nihilism or of death itself, may work against the wishes of the patient.

Keeping the patient's wishes at the top of the agenda can help to shape the type, and place, of care, and ensure that what the patient asks for is adhered to as far as possible. End-of-life care is part of the core business of medicine. Providing the highest quality of end-of-life care should be a fundamental part of all doctors' training and continuing professional development, whether in hospital or in the community.

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