Editorial

the end of life – a subject for all

Laurence Crutchlow is CMF Associate Head of Student Ministries and a GP in London

All your patients will end up in the mortuary. Your personal mortality rate will be 100%.

Think about it for a moment. The young patient who has poor veins after years of intravenous drug use whom you 'save' by heroically cannulating at 3am, will die eventually; she may conquer her addiction but succumb to a stroke in her late 80s. The emergency aortic aneurysm repair patient from the night before may have survived to discharge, but your assistance in surgery doesn't save him from a fatal road accident three months later.

End of life care is a subject for every healthcare professional. No specialism is free of dying patients. But the way we die has changed over the years. Up until the last century, a significant proportion of deaths happened quite quickly. People died in accidents, or developed infections for which there were no effective treatments. Of course some people did survive into old age, but there could be no expectation that everyone would.

Now infections rarely cause death in someone otherwise healthy, at least in the developed world. Public health measures mean that fewer infections spread in the first place. Some 'new' diseases like HIV are a threat, but treatments have been developed relatively fast. Many of us will now live into old age. We will still die, but often of conditions like Alzheimer's disease where our decline is long and slow.

This brings challenges. The very elderly often need social rather than medical care, which is labour intensive. Who should pay? Many are frightened that they will lose dignity at the end of their lives, becoming dependent on others for their basic needs, just as they were as a newborn baby. Some are so frightened of being left dependent on others that they want to end their lives before they reach that stage, leading to pressure to allow assisted suicide or euthanasia.

This edition of *Nucleus* contains a variety of articles that look at medical care at the end of life. We look at practical (page 14), political (page 8), and biblical (page 4) viewpoints, both around euthanasia, and end of life care more generally.

We hope that you'll finish reading convinced that deliberately ending someone's life is not God's way, and with some facts to back yourself up. But we also hope that you will see the wider picture. Of older people respected, included and cared for. Of understanding that 'loss of dignity' may actually be an opportunity for others to serve.

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The care of our patients should be our first concern. Doctors cannot ultimately prevent death; but merely postpone it. Ensuring that our dying patients receive the best possible care at the end of life must surely therefore lead us to consider what will happen after they die. This edition's back to basics article (page 18) looks at ways in which sharing our faith may become part of everyday clinical practice.

Although death is a certain clinical outcome eventually, it isn't the end. Holistic end of life care will not only encompass the here and now, but will consider the patient's future as well. ▪