MJA
from the Editor's desk

DIAGNOSING DYING

Most of us value good experiences: good times, good friends, and a good life. And, as our society ages, of increasing concern is a good death.

In the year 2000, close to 130 000 Australians died. More than 70% were aged 65 years or older, most succumbing to cancer and cardiovascular disease. Most died in hospital.

It is likely that many did not have a good death. In hospitals the pervasive ethos of healing and curing is not conducive to confronting death. Investigations and invasive procedures continue when palliative care is actually long overdue, and technology stubbornly defies death. When death is imminent, feelings of helplessness, guilt or failure are allayed by hiding reality behind closed curtains or abandoning the dying patient to a side room.

Why should this be?

Explanations include the notion that death must be defeated at all costs, or that clinical training focuses more on when to begin treatment than when to stop. But of more immediate concern is a deficiency in diagnosing dying, and the resultant failure to "change gear" from *curing* the living to *caring* for the dying.

In *Care of the dying patient: the last hours or days of life*, UK physicians John Ellershaw and Chris Ward stress that diagnosing dying is a complex process, and barriers to its realisation include "disagreement about the patient's condition, no definitive diagnosis, failure to recognise key symptoms and signs, a poor ability to communicate with the patient or family and medico-legal issues". They note that increased clinical confidence in the diagnosis of dying requires changes in attitudes to research into and education about the process of dying.

With the ageing of our society, this is long overdue.

Martin B Van Der Weyden

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