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Cite this as: *BMJ* 2020;371:m4070<http://dx.doi.org/10.1136/bmj.m4070>

Published: 27 October 2020

PRIMARY COLOUR

Helen Salisbury: Postponing death

Helen Salisbury *GP*

A newspaper columnist recently suggested on social media that responding to the pandemic with a lockdown does not prevent deaths but merely postpones them. Unsurprisingly, there was pushback. Until someone discovers the secret of eternal life on Earth, death can't be prevented. Postponing it is, however, the main purpose of medicine, alongside reducing suffering.

Perhaps what the columnist meant was that the most vulnerable people will catch the virus anyway and some will die, so efforts to slow the spread are merely prolonging harm. If we can't prevent excess deaths from happening, we may as well get them over and done with quickly, to allow our economy to reopen and flourish once more.

However, there are problems with this generous reading. Many of us (and not only doctors) are still haunted by the images from Italy and Spain during the first wave of the virus: the people lying in hospital corridors, the systems and individuals utterly overwhelmed by an influx of very sick patients. It's clear that some of the early deaths could have been prevented with more staff, medicines, oxygen, and ventilators. If the flow of patients into a hospital is moderated, more resources are available to give each patient the best chance of recovery—and possibly to postpone their death by years or decades.

Some commentators complain that the focus on coronavirus is disproportionate, preventing proper care for other illnesses. It's certainly true that, while hospitals and intensive care units are full of patients with a highly contagious virus, there are inevitable restrictions on treating other conditions. As many as 18 000 excess cancer deaths are estimated this year because of delayed presentation, diagnosis, and treatment.¹ Short of turning away patients with covid-19, however, we have no choice but to divert resources to this immediate problem.

The most effective way of postponing deaths is to reduce the transmission rate of the virus. There isn't a magic bullet, but there have been useful illustrations of a "Swiss cheese" model of pandemic control²: here, no single element is sufficient by itself (they all have "holes"), but by running these alongside each other we have a good chance. These elements include face coverings, social distancing, handwashing, open windows, rapid and accurate testing, contact tracing, and isolation with support. How well each of these is done will determine how big the "holes" are in each cheese slice and how effective their combined protection is.

My small contribution is to keep my surgery as free of infection as possible. This means doing as much work as we can remotely, to limit the footfall in our

building. I wouldn't choose to consult this way, and many of my patients don't like it much either—but most are sensible enough to realise that we don't have a choice.

Competing interests: See www.bmj.com/about-bmj/freelance-contributors.

Provenance and peer review: Commissioned; not externally peer reviewed.

- 1 Health Data Research UK. The Big C isn't covid-19—it's cancer. 25 Aug 2020. <https://www.hdr.uk.ac.uk/news/the-big-c-isnt-covid-19-its-cancer/>.
- 2 D'Amore R. What is the 'Swiss cheese model' and how can it apply to coronavirus? *Global News* 2020 Oct 13. <https://global-news.ca/news/7393839/coronavirus-swiss-cheese-model/>.

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