Helen Salisbury: Death—the great leveller?

Ideas of what counts as a good death are probably quite varied, but most would agree that it should occur in old age and with minimum suffering. Roger McGough famously asked for a young man’s death in his poem, describing (among other possibilities) revenge from a jealous lover at the age of 104. I had a family friend who died at 84 while playing tennis—still with full use of his limbs, eyes, and brain and, right up until the final moment, still actively engaged and in good company.

But sudden stops are hard on the people left behind, so perhaps, given the choice, we’d opt for a brief but painless illness, allowing time to gather the people we loved around us and say goodbye, with a chance for those last conversations that survivors often regret not having.

As a GP I’ve been lucky to witness some good and gentle deaths. I particularly remember a patient cared for at home who, after a long life and a short illness, was offered mouth care by the family using those little pink sponges-on-sticks, dipped in champagne. I’ve also listened to the often overwhelming distress of relatives recounting deaths that were anything but gentle, with uncontrolled symptoms or unwanted medical interventions.

Death is the proverbial “great leveller” because we can’t take our status, wealth, or fame with us beyond the grave. But, right up until that moment, inequality is present, for patients and for those around them. A recent report to the UK parliament states that each year 100 000 people who could benefit from palliative care die without receiving it. There’s a clear socioeconomic gradient to this, with patients from deprived areas more likely to die in hospital (few people’s choice of a good death) rather than in a hospice or at home. This applies even to those known to palliative care services. Bereaved relatives of patients in poverty are also less likely to believe that they received sufficient support while their family member was dying, or that they were treated with dignity at all times.

There are many explanations for inequalities in access to palliative care, perhaps partly because doctors are better at recognising the end of life approaching in patients with cancer than in those with other conditions. Cancer causes a greater proportion of deaths among the most socioeconomically advantaged people than among the most deprived. To help this latter group, we need to become better at recognising and referring patients with end stage lung and heart disease to palliative care services.

I suspect that having a doctor who knows you also affects your chances of access to palliative care. Someone who sees you over time will not only note your failing health but is more likely to be a person you trust enough to talk to about death. What’s certain is that more resources for the community palliative service, along with improved continuity of care from GPs, would help more of our patients to have a good death.

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3 Macfarlane M, Carduff E. Does place of death vary by deprivation for patients known to specialist palliative care services? BMJ Support Palliat Care 2018;8:-3. doi: 10.1136/bmjspcare-2016-001099 pmid: 27934630