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Too much outcry about quality of life, what about the quality of death?

Abstract

With human civilization stepping into a revolutionary era of health, Quality of death is becoming an increasingly concerning aspect among the health care providers in palliation, intensive care units, or end-of-life care. Unfortunately, the people at the receiving end of these services are mostly clueless and find themselves surfing blindly through this whirlpool. As for the countries ranking low in the quality of death index, the culprit could be an actual unawareness of the general people as to what and how to achieve a "Good Death". Various measures that can be adopted to achieve this common goal include providing a safe space to share and talk, using digital platforms and organizations for spreading awareness through the common masses, helping insight development into own death and training more healthcare workers in providing these services. It takes foresight and timely action that can help ensure you can get a "Good Death".

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Quality of life (QOL) is defined as "an individual's perception of their position in life in the context of the culture and value systems in which they live and concerning their expectations, objectives, concerns, and values" [1]. Quality of death (QOD) is generally defined as the degree to which a person's preferences for dying and the moment of death agree with observations of how the person actually died [2].

Despite QOD becoming an increasingly popular and concerning aspect among the health care providers in palliation, intensive care units, or end-of-life care, the people at the receiving end of these services are still mostly clueless, and finding themselves surfing blindly through this whirlpool.

Interestingly, the concept of death is a subjective idea that individuals learn from their respective experiences in life. However, at an individual level, whenever the thought of our own death hits us, the following terms are a few of the simplest definitions of a good death we hear and wish for:

— dying without pain
— dying in sleep
— dying suddenly
— dying quietly
— dying at home with family.

Despite death being an inevitable truth, the discussion surrounding death and end-of-life care still stays an unwelcome and uncomfortable topic in a group.

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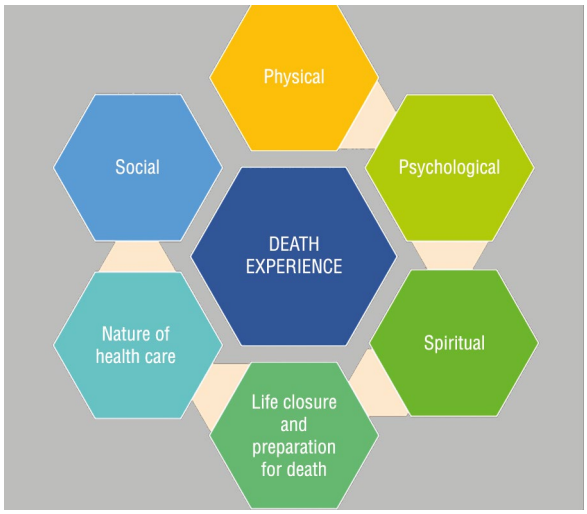

Figure 1. The spectrum of the experience of death

The situation is such that whenever the topic comes up, others in the group just try to cheer up the speaker telling "Don't worry", "Let us talk about something positive", "No such evil shall occur", etc. The outcome is that the physical, emotional and psychological measures needed to ease the transition are delayed until the phase of impending death. Everyone is worried about the quality of life and after death, having life insurance, etc. to provide for the financial needs of their families. The multimillion-dollar sectors are being run on health and death insurance.

There is also no denying the fact that the alleviation of suffering is universally acknowledged as a cardinal goal of medical care. Amongst all this, the concern about the quality of death gets undermined somewhere. Interestingly, the total number of sudden deaths has been evaluated to be less than 10% [3]. This implies that most people have a slow death where relevant measures can be employed to achieve a good quality of death. The goals of care should be the alleviation of suffering, and optimization of the quality of life till death, accompanied by an optimization of the quality of death. The motive is not just to die peacefully but to live peacefully until we die.

The responsibility of healthcare providers should not simply be limited to being able to cure or not to cure. As for the strata at the receiving end (patient and their families), the awareness of the concept and significance of quality of death needs to be encouraged. The simplest question enveloping the whole idea can be "What do you wish your death to be like"?

The process of death is a multifaceted experience. The various domains of this experience have been depicted in Figure 1. It needs to be understood by every individual that the quality of death is not

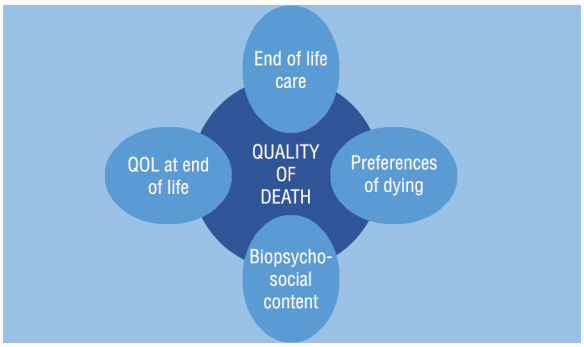

Figure 2. Entities overlapping with quality of death

synonymous with quality of care at the end of life, preferences of dying, quality of life at the end of life and biopsychosocial content. QOD has a much broader scope altogether with overlap among these domains (Fig. 2).

Currently, the medical professionals involved in palliative and end-of-life care are getting more concerned with improving the quality of death of their patients. Various death quality indices are being used in health care to evaluate the same [4]. In 2015, Lien collaboration and Economist Intelligence Unit published the 'Quality of Death Index' in which India ranked 67th and the UK ranked first among 80 countries throughout the world [5]. This depicts the state in which people are actually dying. As for the countries ranking low in the quality of death index, this could be due to the actual unawareness on the part of general people as to what to do, and how to do, to achieve the death they wish. Hence, they need to be brought on board to achieve this common goal.

The following methods can be adopted to help the patient and his family in the process of optimizing the quality of death:

1. The first and foremost measure is to talk openly and without hesitation about the topic of death so that there is no discomfort or awkwardness involved. A safe open space to share can open avenues for better measures.
2. The digital world has become the lifeline of communication today. Social media and digital platforms can reach even the remotest of areas. Articles, Blogs, and Specialist talks can be shared through these, with even the common people expressing their opinions, and asking their queries.
3. Different organizations and foundations can be brought together to organize campaigns, rallies, and street shows. This can help form a chain spreading awareness aimed at bringing about change on a larger scale.

4. In the health sector, providing the patient and family with the necessary honest information from the health care provider so that they can clearly set their priorities and goals of care.
5. Helping the patient to develop insights into their deaths. The process of death can be fearsome. Their worries and queries regarding helplessness, dependence on others, leaving family behind, unfinished business, etc. need to be allayed. This would include allowing them the opportunity to resolve any personal conflicts and saying goodbyes. The motive is to bring the patients and relatives to peace with the impending death.
6. Providing a common language for healthcare professionals involved in end-of-life care and the patient side.
7. Training more healthcare individuals in delivering services for ensuring good quality of death. The knowledge and skills to handle the patients and their families at this sensitive junction of life should not only be limited to Palliative care specialists.

This article aims to send a reminder that for the success of any service, both the service provider and the service beneficiary must be well-versed in the whereabouts of the process. This concept needs to be spread throughout the masses in an efficient way such that the process of good-quality death can be put in motion early on. There is huge importance being imparted to good birth, maternal, and child health. An equal emphasis needs to be put on good death, patient, and family health (as death is an equally important life milestone). Everyone wishes for a "Good Death", but it's foresight and timely action that can help ensure you can get one.

Declaration of conflict of interests

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