Editorial : The Way We Die
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Palliative care in Hong Kong has a history of more than 20 years. History has made what we are now today, but we need to build on history, and not just looking back at history. Our philosophy has not changed, but the service delivery and the professional development have developed considerably. As Dr. KS Chan has rightly mentioned, what we serve and do should match the needs of our time. As for the future of palliative care in Hong Kong, I do not have a crystal ball to give you the answer. However, I would like to share with you my contemplation on the way we die.

People now die differently from the ancestors. There is an old famous Chinese saying: "human living beyond age 70 was a rarity in history of mankind". In the past, people got married before age of 20, and became grandparents before age of 50. Our body is at the prime time of reproduction at age 20 or younger, and advances in science have not changed this fact. With modernization of the society, our prime time is that determined by other aspects – career, possession, and achievement – and reproduction is usually pushed way behind the natural prime time.

A life span of 70 years is no longer a rarity now. Human can live above 80, 90 or even 100. Medical science has also modified our dying trajectory. Contemporary dying is characterized by aging and a slow decline process, and death is the destiny of the long journey. Dying can be a lingering process, one being described as an "entry and re-entry" death; where patients have repeated admissions into hospitals before they die.

Predicting end-of-life is not as easy as one would think. The "end"-of-life may stretch beyond a short period to that of a few years, which are punctuated by hospital admissions and interventions. The delineation of end-of-life may not be clearly recognized by health care workers, not to say by the patients and their families. A few weeks ago, I saw a 93 yr-old gentleman in the acute medical ward. He was admitted from an elderly home in a febrile, poorly nourished, dehydrated and hypoxic state. After investigation, he was found to have empyema. He was on oxygen supplement, and his conscious level was impaired. It was quite clear to me that his prognosis was guarded, and the battle to overcome the severe infection might be too difficult for this frail patient. I asked the young doctor what he would consider reversible in this patient as a guide to the care plan. While I was having the dehydration and symptoms in mind, he said it was the empyema. I was surprised that he could hardly recognize that the patient was dying, but was so occupied by the fact that the entity of empyema is potentially treatable.

Most deaths do not come along drastically without any preceding signals. Our bodies suffer from wear and tear as time goes by. Instead of "one-man-one-disease", each of us may carry a cumulated list of various chronic illnesses. In one study in US, more than 4000 patients were studied for their patterns of functional decline at the end-of-life. Decedents were grouped into 4 theoretical categories trajectories of dying, namely sudden death, terminal illness of cancer, organ failure and fragility. The cancer group was the youngest (mean age 78.7± 6.9 yrs), whereas the fragility group was the oldest (mean age 85.1± 7.2 yrs). Except for the sudden death group, the other groups of decedents had substantial decline in function in the last 3 months of life. However, those with cancer were relatively well before this decline, while the fragility group was in general more disabled throughout the last year. The organ failure group ran a more fluctuating course. The pattern of decline varied with the underlying illness. (Fig) The authors concluded that planning of end-of-life care should take such variations into consideration. Those who were in the group of lingering death or the entry and re-entry group might need palliative care, but a need not identified because of the absence of a clear terminal stage.

![Fig. Dying trajectory of patient groups (adapted from Linney et al)](Image)

Unless we recognize dying, we will not prepare for it. Unless we recognize the end-of-life of our patients, we will continue to adopt a "repairing-body-parts" approach instead of total patient care.

Aging, rapid advances in medical technology, and restricted resources are key drivers for health care reform, our government says so. From the perspective of a palliative care physician, these factors not only affect the way we live, but more importantly, the way we die. I am not a geriatrician. To the best of my knowledge, aging is far more than dying at a later age. Unless we recognize the end-of-life of our patients, we will continue to adopt a "repairing-body-parts" approach instead of total patient care.

References:

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