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Reviews

Personal views

Can I choose the cause of my death?

Death is an ultimate truth. It can only be postponed, not denied. Since the sum total of the probabilities of death by various causes is one, they end up competing with one another. If I do not die from tuberculosis I may die from cancer. This raises the question of whether medical science should focus on some specific causes of death at the expense of the others.

Heart failure in old age need not be prevented but possibly promoted

If deaths cannot be prevented altogether are there any causes more desirable than others? In a survey in Japan old people expressed a preference for heart disease as the cause of death rather than dementia, cancer, or stroke. Most would agree that sudden death is far more welcome than a slow, incapacitating, and painful death. It would be nice to see a day when everybody would die suddenly in old age without suffering from infirmity or distress. Clearly, there is a case for identifying risk factors of sudden death in old age, and to nurture them instead of controlling them. Medical science seems not to have deliberated sufficiently well on narrowing the spectrum of causes to a few desirable ones.

"Behold the signal of Od Time": scene *from The English Dance of Death* by William Combe, c1815

There is substantial evidence that acute myocardial infarction is the predominant cause of sudden death in old age, particularly when unnatural causes such as accidents are excluded. Considering that there is no escape from death, that sudden death is more desirable in old age, and that acute myocardial infarction is the predominant cause of sudden deaths in this age, the whole spectrum of research on risk factors for acute myocardial infarction needs a fresh look. The disease is increasingly affecting younger people—that certainly deserves full attention. Risk factors of myocardial infarction in young people should be delineated with far more precision than is done so far, and everything possible should be done to control them.

But the point of my argument is just the reverse for factors of acute myocardial infarction in old age, especially when it causes sudden death. The risk factors for these deaths also need to be delineated with the same degree of earnestness, not for the purpose of their control but to cultivate them. Heart failure in old age need not be prevented but possibly promoted, lest increasing infirmity takes its toll. Many physicians around the world may abhor this idea but I am convinced. Mega-projects, such as Inter-heart study (www.ccc.mcmaster.ca/projects/interheart), need to focus not just on finding treatment strategies but also on locating more cases of sudden death in old age that might be getting excluded, so that the factors leading to such deaths can be identified with greater precision and granted respect in life. Treatment strategies should be focused on the younger patients.

What age is old enough to be considered old? Evidence suggests that the maximum attainable life expectancy is 85 years. Many people, however, spend a substantial part of old age in a debilitating condition. According to a recent calculation, the percentage of remaining life at age 60 years lived with severity

adjusted disability ranges from 22 to 53 in different regions of the world. Until such time as further success is achieved in adding life to the gain in years, the age of 80 and above can be arbitrarily considered old enough for the purpose of identifying factors contributing to sudden death. Thus, in the case of acute myocardial infarction, risk factors for sudden death beyond 80 years of age can be considered good for nurturing.

As a corollary, this also underscores the need to increasingly target those ailments that cause long term and severe disability compared with those that cause death in old age. Thus, there should be an increasing focus on diseases such as cancer and AIDS rather than acute myocardial infarction. Deterioration in quality of life after acute myocardial infarction is rarely as much as in advanced stages of cancer or AIDS.

Footnotes

If you would like to submit a personal view please send no more than 850 words to the Editor, BMJ, BMA House, Tavistock Square, London WC1H 9JR or e-mail editor@bmj.com

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