
The final journey

EDITORIAL

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The dead have never been a prioritised task for doctors. We are responsible for the living. But do we also have a responsibility for those who are responsible for the dead?

The living before the dead. The principle of battlefield medicine applies also in A&E clinics in peacetime. The living can and should be helped. The dead are dead and beyond help. They must wait. When a death occurs in the patient's home, a doctor is required to verify the death and confirm in writing that the person is dead, and that the death occurred from natural causes [\(1, 2\)](#). Only then can the family and the undertaker start planning the final journey.

The Norwegian Index for Emergency Medical Assistance [\(3\)](#) has three levels: red (acute), yellow (urgent) and green (normal). If the request is characterised as having a *normal* degree of urgency, it will not be prioritised. According to this organisation, the dead will always have to wait. They come last. Those who watch over the deceased person will thus also have to wait. The family must wait. The same applies to the undertakers who will take the deceased person away. If the GP has gone home or is unavailable, the A&E clinic is busy, it is late at night or the death has occurred in a rural inland community far from the central A&E clinic out on the coast, the wait can sometimes be lengthy. This can be hard for the bereaved family. It can be problematic. And some regard it as a disgrace.

In the Journal of the Norwegian Medical Association, Anne Marit Sand and colleagues are now presenting a qualitative study on issues regarding collaboration between agencies involved in handling of deceased persons in cases of expected deaths in the home in a large urban municipality in Norway

(4). The study is based on an analysis of five focus-group interviews undertaken in 2015 and 2016, involving the professional groups of homecare nurses, GPs and employees of firms of undertakers. The interviews are supplemented by data from a questionnaire survey sent to leaders of major firms of undertakers and A&E clinics in other regions in 2018.

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The study reveals and discusses from the authors' point of view considerable challenges in the coordination and dignified handling of deceased persons and bereaved families in cases of deaths in the home. The causes of these difficulties include long waiting times before the doctor's verification, lack of clarity regarding the responsibilities of the homecare nursing service and lack of understanding on the part of certain agencies in the primary healthcare services of the needs of the deceased, the bereaved and the undertakers.

I, like the authors, have also been unable to find equivalent studies that shed light on this issue. The authors should be commended for having conducted this study. It is informative and gives food for thought. It contains clear recommendations for improvements in current practice, with a basis in the international recommendations from the World Health Organization on palliation (5).

One weakness of the study is the uncertainty about its external validity and transferability to other municipalities and regions, which is also pointed out by the authors themselves. We now know that challenges existed when the researchers collected their data, but we do not know whether they still persist, nor whether this particular urban municipality is representative of the country as a whole. We lack a broader evidence base, and being able to answer such questions might be useful.

In 1990, altogether 18 % of all deaths occurred in the home. In 2018, this figure was 13 %, or 5 223 persons (6). It is a low number, and it is decreasing. In a well-written and concise editorial comment in the Journal of the Norwegian Medical Association in 2012, Bettina S. Husebø and Svein Husebø wrote that there is an explicit wish and an unmet need for more people to die with dignity at home (7). They underscore that the doctor has a key position, but that there is also a lack of clarity regarding the doctor's responsibility. International data indicate that appropriate care of the bereaved by the healthcare workers who have been responsible for the patient up to the time of death is of importance for the processing of grief and acceptance after the death of a patient (8, 9).

So yet again, this is a question of priorities, resources and time in hard-pressed GP and out-of-hours schemes as well as among hardworking homecare nurses. Facilitating good collaboration between the parties involved and ensuring that doctors take responsibility for those who are responsible for the dead is fully possible.

If we have the resources, we can do it.

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