stable individuals, is stopping or switching to more tolerable medications safe and effective?

A new generation of maintenance studies should be implemented, which adopts a participatory approach with patients to optimise outcome measure selection and further elucidate adverse events with standardised tools to allow for data pooling. Comparative efficacy and tolerability between antipsychotics should be prioritised in trials over placebo-controlled discontinuation trials. Maintenance trials in LMICs should be effectively implemented to increase the generalisability of results to real-world populations. Future maintenance studies should be implemented within a culture of data sharing,[13] which would allow large-scale primary research synthesis such as individual participant data meta-analyses aiming to identify adverse event predictors and ultimately help to tailor the choice of antipsychotics according to individuals' characteristics.

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The precariousness of balancing life and death

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Despite the centrality of death to our lives, people from many societies avoid meaningful conversations about death, and its value as a fundamental human experience has been largely lost. Diminishing the inevitability and humanity of death has obscured our understanding of health and life.

Dying in the 21st century is, as highlighted in the *Lancet* Commission on the Value of Death,[1] a story of paradox. Advances in technologies, science, medicine, artificial intelligence, and pharmaceuticals have saved lives but have complicated death in high-resourced health systems. Many people today die after substantial efforts at what is often called futile care. Such overtreatment in hospitals, mostly serving those with higher socioeconomic status, contrasts with a great global abyss of undertreatment.[2] From the perspectives of those living in countries without adequate health resources, dying is too often characterised by gross inequity in access to basic care or support. More than 61 million people globally experience serious and avoidable health-related pain and suffering, and many people continue to die from preventable illnesses.[3] The poorest 50% of the world's population live in countries that have only 1% of the distributed morphine equivalent medication essential to alleviating pain.[4]

Is the *Lancet* Commission on the Value of Death relevant in countries where the challenge is to constantly balance dying and death in poverty and inequity? In countries where universal health coverage is missing, multiple factors can determine death and dying. These include insufficient services,

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resources, training, or drugs; the cost of accessing care; reluctance of health staff to break bad news because of cultural, social, and time pressure reasons; not receiving the right level of care with costly interventions; barriers in getting to the right or the safe place to die because of siloed health services or the absence of basics such as sheets, mattresses, hygiene, and running water. All these factors can be addressed. Unlike so many other priorities in global health, affordability is not the greatest barrier for all countries to deliver services of care to die well; valuing those who are dying is.

Dying has become one of the costliest health-care events. Spending in the last year of life accounts for a disproportionate share of total health expenditure in high-income countries notes the Commission. The global gap in services and therapies does not mean death or dying is cheap for people living in low-income countries. Inadequate investment in effective palliative care interventions in these settings contributes to intergenerational poverty, with children taken out of school when savings for education are used instead for care.[5]

The Commission draws parallels between the need to rebalance our relationship with death with that of balancing our relationship to the planet. The climate crisis, ecosystem collapse, and biodiversity loss are not only causing untimely deaths, but also point towards planetary death. Ill health and death have been brought closer by the direct and indirect impacts of climate on health, but as more demands are put on the health sector the more the sector becomes a driver of the climate crisis.[6] Is this fractured relationship with nature connected to a detachment from death and the way societies have deluded themselves into believing both nature and death can be manipulated, tamed, and managed?

The Commission uses the construct of "death systems" to explore the complex components that determine how care of the dying and the dead is given, who is included and excluded from such care, where care happens, and the dynamic shift in who "owns" death. 30 recommendations are made to bring about radical change in death systems, acknowledging that death systems are unique to societies, shaped by culture, history, religious beliefs, and resources. But what happens when the death of those who speak out against the state or who are members of minority communities is pursued by a political regime, or when dying is on such a scale that the death system breaks down, such as in Yemen, and Syria, and increasingly in Afghanistan?[7–9] With the 21st century expected to be a century of mass migration, lessons need to be learned from refugees, internally displaced peoples, women and girls who are trafficked, and persecuted communities who are balancing life and death in fragility. The experiences and priorities of these groups do not feature in the Commission. Does death hold a different value in contexts of political oppression or migration? Or of entrenched racism, xenophobia, or misogyny including femicide? The anniversary of the 2021 military coup in Myanmar on Feb 1, 2022 is a stark reminder that health workers have been the target of violence and death by the military regime.[10,11] The Rohingya community in Cox's Bazar, Bangladesh, and refugees making crossings of the Mediterranean have had to develop ways of facing death and caring for the dead and dying which sit outside the surrounding societal structures and norms.[12,13] In these cases death and life will struggle to be "rebalanced" as the Commission proposes.

As the Commission highlights, death occurs through conflict, accident, natural disaster, pandemic, violence, suicide, neglect, or disease. The *World Economic Forum Global Risks Report 2022* identifies the ten most severe risks over the next 10 years, including livelihood and debt crisis, severe weather, infectious

disease, environmental damage, and geo-economics confrontation, and points to a world where there will rarely be a singular cause of death.[14] Perhaps the greatest challenge societies face in repositioning death systems will be to move from siloed sectors into interconnected ones.

In so many societies we have lost trust in, and relegated, our ability to deal with death. The medicalisation of death and the capability or otherwise of a health system to manage death has come to determine the way that death is treated. The Commission argues that only by re-establishing the value of death will we be able to transform our health systems. The Commission offers a vision of a new system for death and dying underpinned by five principles—tackling the social determinants of death, dying, and grieving; seeing death as a relational and spiritual process; enabling networks of informal and formal care; normalising conversations and stories of death, dying, and grief; and recognising death has a value. This framing points to ways to improve the experience of death and dying globally. Achievement of the Commission's vision will require a renewed belief in a shared humanity and the recognition that we are born equal, but into very unequal circumstances, and although we cannot change the inevitability of death, societies can change the circumstances to avert preventable deaths and provide the time, space, comfort, and compassion to die.

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