

## Talking about death and dying: A delicate balance between the physician, patient, and their family caregivers

We thank the authors, Shah and Tiwari, for their evocative paper on passive euthanasia within the Indian healthcare setup.<sup>[1]</sup> The paper contributes to the larger discourse on the ethical dilemma of the right to die with human dignity. It highlights the need to initiate a dialogue within the Indian healthcare system regarding the introduction of communication skills for physicians and the practice of seeking healthy (and legal) consent when providing a diagnosis to the patient and their caregivers. This grants them the agency to actively participate in determining the quality of both their life and death.

To ease the dilemma, the Indian Council of Medical Research Expert Group on “Do Not Attempt Resuscitation” (DNAR

or passive euthanasia) highlighted the importance of open communication between the physicians and the patient/family caregivers to enhance the decision-making process.<sup>[2]</sup> In order to encourage open communication among the triad (patients, family caregivers, and their physicians) involved in illness communication in the Indian medical setting, it is necessary to recognize two unique aspects.

First, India being a collectivist society, the agency and responsibility of the patient, especially in the case of terminal illness, are primarily vested with the family caregivers. This often overshadows the patients’ agency and role in the decision-making about their own bodies.<sup>[3]</sup> The vulnerable

state of the patients renders them dependent on their family caregivers, who act as consent providers in treatment and medical decisions.<sup>[4]</sup> Despite their need for information regarding their illness and treatment, the patients play a passive role in illness communication and decision-making. Acknowledging the narratives of the authors of the current paper, research suggests that to provide consent for medical decisions, family caregivers have to engage in pragmatic questioning.<sup>[1,4]</sup> Often the family caregivers are forced to make a choice between the patient's quality of life or continuing medical care. This dilemma results in feelings of guilt among the family caregivers. It is therefore crucial to recognize and involve the family caregivers in end-of-life decision-making and interventions.

Second, patients and their caregivers in India prefer that their physicians initiate illness and treatment discussions.<sup>[4]</sup> Therefore, it is essential for physicians to lead discussions on DNAR/end-of-life. However, medical education in India does not offer training for communication skills as part of the curriculum.<sup>[5]</sup> The ramifications of not offering such training programs are also hinted at in the current paper, wherein physicians expressed fear and hesitancy to initiate conversations about DNAR with patients and caregivers.<sup>[1]</sup> It is imperative that a communication skills training program be included for physicians to focus on breaking bad news and open dialogue to having end-of-life conversations.<sup>[6]</sup> Further, cultural sensitivity needs to be incorporated while developing end-of-life interventions for patients.<sup>[7,8]</sup>

To this end, we believe that achieving dignity in death is a process that begins with initiating sensitive conversations from the physician's end. Furthermore, open and collaborative communication between the patient, physician, and family caregivers is required to ensure an ongoing dialogue on end-of-life care. This may help normalize conversations on death with dignity, bearing in mind the unique challenges of the Indian medical setting.

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### Conflicts of interest

There are no conflicts of interest.

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