Author's Reply

Dear Editor,

In response to the letter by Naik *et al*.,[1] we would like to thank the authors for their interest in improving end-of-life care (EOLC) in the Indian setting. End-of-life decisions (EOLD), particularly foregoing life-sustaining treatment (FLST) involve a complex decision-making process. The Indian Society of Critical Care Medicine (ISCCM) and Indian Association of Palliative Care (IAPC) have come together[2,3] to develop a decision-making pathway to arrive at these decisions through consensus between caregivers and the family. This is because 95% of patients[4] and 50% of families[5] are found to be too incapacitated to take decisions. For a section of the Indian population, "weak paternalism" by the physician may be necessary to facilitate this process. However, this approach should always be founded on eliciting the concerns of the families and on the best interests of the patient.

Having an independent EOLC support unit as suggested by Naik and Biradar can be useful but usually decisions are arrived at through repeated dialogue between the caregivers and the family. It is indeed

good to have a hospital committee that oversees all the requirements for quality EOLC viz., presence of trained health care staff, stocking of essential medication for symptom control, institutional EOLC policy and standard operating procedure etc. They may also serve to counsel family or treating physicians in case of dispute. Any legal advisor in the committee should be well-versed in the needs of the terminally ill patient as the law in India relating to FLST is relatively primitive and ambiguous at present.[6] Detailed practice points are spelt out in the joint statement[2] so that EOLDs are possible for any physician caring for the critically ill whether in a big hospital or in a peripheral facility.

The main barrier to EOLD is the physician apprehensions of litigation and legal liabilities.[7] This is contrast to the industrialized world where such decisions are increasingly found to be less difficult.[8] In the US, Europe, and Australia, laws are more settled although still in evolution. The newer sophistication of organ support has brought with it new ethical dilemmas and interpretation of ethical principles.[9] Although the end-of-life practices vary with cultural and religious differences, a powerful international consensus has emerged.[10] Against this backdrop, we find ourselves seriously mired in an outdated legal framework. The ISCCM-IAPC position statement is an effort at motivating physicians to offer reasonable and practical end-of-life solutions.

Indian Society of Critical Care Medicine and IAPC have also taken initiatives for education and training in EOLC.[11] The training module addresses the entire gamut of issues from early recognition of dying, initiating discussions, communication skills, breaking bad news, documentation and implementation of decisions, and palliative support to bereavement care. In addition, joint initiatives are on to inform legal opinion in the country about EOLC. With increasing awareness, the consensus among healthcare professionals and determined advocacy, appropriate FLST and care of the dying should be possible without too much procedural difficulties.

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References

1. Naik BS, Biradar S, *et al*. End of life care policy: An integrated care plan for the dying. Indian J Crit Care Med 2015;19: 240..
2. Myatra SN, Salins N, Iyer S, Macaden SC, Divatia JV, Muckaden M, *et al*. End-of-life care policy: An integrated care plan for the dying: A Joint Position Statement of the Indian Society of Critical Care Medicine (ISCCM) and the Indian Association of Palliative Care (IAPC). Indian J Crit Care Med 2014;18:615-35.
3. Mani RK. Coming together to care for the dying in India. Indian J Crit Care Med 2014;18:560-2.
4. Azoulay E, Sprung CL. Family-physician interactions in the intensive care unit. Crit Care Med 2004;32:2323-8.
5. Pochard F, Azoulay E, Chevret S, Lemaire F, Hubert P, Canoui P, *et al*. Symptoms of anxiety and depression in family members of intensive care unit patients: Ethical hypothesis regarding decision-making capacity. Crit Care Med 2001;29:1893-7.
6. Aruna Ramachandra Shanbaug vs The Union of India & Ors. WRIT PETITION (CRIMINAL) NO. 115 OF 2009. (Supreme Court of India Proceedings).
7. Barnett VT, Aurora VK. Physician beliefs and practice regarding end-of-life care in India. Indian J Crit Care Med 2008;12:109-15.
8. Sprung CL, Woodcock T, Sjokvist P, Ricou B, Bulow HH, Lippert A, *et al*. Reasons, considerations, difficulties and documentation of end-of-life decisions in European intensive care units: The ETHICUS Study. Intensive Care Med 2008;34:271-7.
9. Rady MY, Verheijde JL. End-of-life care and the withdrawal of cardiorespiratory life support: Are practice recommendations trustworthy? Crit Care Med 2013;41:2813-5.
10. Sprung CL, Truog RD, Curtis JR, Joynt GM, Baras M, Michalsen A, *et al*. Seeking worldwide professional consensus on the principles of end-of-life care for the critically ill. The Consensus for Worldwide End-of-Life Practice for Patients in Intensive Care Units (WELPICUS) study. Am J Respir Crit Care Med 2014;190:855-66.
11. Iyer S. Challenges in the implementation of "end-of-life care" guidelines in India: How to open the "Gordian Knot"? Indian J Crit Care Med 2014;18:563-4.

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