

Quality life or quality death: do we need to shift the paradigm?

Editorial

जातस्य हि ध्रुवो मृत्युर्ध्रुवं जन्म मृतस्य च।
तस्मादपरिहार्येऽर्थे न त्वं शोचतिमर्हसि॥

jātasya hi dhruvo mṛtyur dhruvaṁ janma mṛitasya cha
tasmād aparihārye 'rthe na tvam śhochitum arhasi

A famous devotional verse taken from the holy *Srimad Bhagavad Gita: Chapter 2, Verse 27*, means death is certain for one who has been born, and rebirth is inevitable for one who has died. Therefore, you should not lament over the inevitable. As healthcare professionals, we fight with the ailment till the last breath of life and we expect from the patients and their family members the same fighting spirit till the end with full a positive approach towards life. Unfortunately, there is big imbalance of reality and expectations occurred between the healthcare professionals and the patients and their family members. We doctors, as per our training never give up hope of patients being cured by the healthcare facilities available to us. But at times, we know that further treatment is not going to benefit the patient but rather will cause more pain, anguish, and deterioration, then we need support from the patients and family members to understand the situation with a broad-minded and practical approach.

World-wide India has one of the most highly privatized healthcare systems.¹ Private hospitals and health care agencies contribute the majority of the ICU beds as compared to public hospitals. Unfortunately, the majority of the population who need ICU care belongs to low or lower middle socio-economic strata. So most of the families bear the expenses on their own savings and earnings.² It is estimated that ICU admission costs may be 100 times per capita income, and a single ICU admission can bring families to extreme poverty.³ The recurring cost of medicines, drugs, and investigations were the major problem to the patients admitted to government-funded public hospitals.⁴ A multicentric study (120 ICUs) reported that only 17% of the ICU patients' costs was borne by their insurance or employer, and 81% of the patients made their payments from their pockets.⁵

The socioeconomic effect of ICU admissions extends beyond the capacity of the individuals or family members in India. Family members of critically ill patients admitted to the ICU experience significant problems in regard to psychological and social functioning.⁶

Anyone might not understand except the suffering patient that an ICU is an appalling abode to die. In my opinion, the people should die in their own beds, surrounded by their families and in their own familiar cozy atmosphere. ICU treatment till the last breath gives only ultimate what we call medicalized deaths. The *Lancet* Commission identified key elements of this phenomenon: Death is happening more often in hospitals than homes, there is increasing use of futile or inappropriate medical treatment near death, and families and communities are less involved than they used to be. Libby Sallnow, co-chair, of the *Lancet* Commission on the Value of Death said that "*How people die has*

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changed dramatically over the past 60 years, from a family event with occasional medical support, to a medical event with limited family support." By giving time, attention, and compassion as people die, we connect with them and with our shared fragility, pushing us to acknowledge our interdependence and understand what is at the core of human relationships.⁷

If there is no hope of a cure and pain is unavoidable in carrying life, one should try to make the environment at least bearable. The Pain of life should be less than any treatment to live that life particularly when the pain of treatment is prolonged and impractical. Unfortunately, many cancer patients have a very limited scope of treatment in terms of efficacy and affordability which ultimately lead to long and slow process of dying with so many complications of the disease. As our economy is growing very rapidly and paying capacity of the general people have increased manifolds, therefore they seek a better quality of healthcare for themselves but living longer does not necessarily sounds like living healthy and living better.

With the advent of modern healthcare facilities and advanced medical technology, there is an increasing emphasis on clinical interventions and treatments, but in many cases, all they do is stave off death, often at the cost of quality of life. If there is no perfect and permanent cure available, one must look for good palliative care which ultimately gives relief from physical, psychological, and emotional suffering, not only for the patient but also for their family. Home-based palliative care, and family education for the better care of the patient in a homely environment with their kids and relatives alleviate the pain of suffering much more effectively than any sort of treatment, especially when there is no treatment left. Unfortunately, due to a lack of awareness and limited resources for palliative care, many patients got trapped in a needless and futile clash with their medical conditions, which makes death less peaceful than it could be for them and their loved ones.

Initially, the doctors hid the bad prognosis, worst responses, and situations of the patients from the patients and their attendants and always tried to console and convince them to come out of the bad

situation. Despite knowing a bad truth, they tried to pacify the patients and their attendants and gave them hope of being cured and having healthy life forever. But with the advent of Consumer Protection Act 1986 creating Consumer Disputes Redressal Agencies, drastic changes occurred in their behavior and attitude. Now it is necessary to tell each bad and worse condition to the patients and attendants irrespective of how much it causes mental trauma and emotional setbacks.

Now healthcare professionals are helping terminal cancer patients in alleviating their anxiety and spiritual suffering.^{8,9} These terminal patients despite treatment attempts suffer in various ways; physical pain, loss of meaning, loss of autonomy, feeling of being a burden, and fear of future suffering.¹⁰ They are making every effort for these terminal patients so that they must try to accept this “uncontrollable destiny” by accepting a limited life, an unsatisfactory body, and distressing circumstances as part of “I have to accept it.” Patients are reconciled with their lives and trying to stabilize their minds each day. “I have to accept it” will be the expression in the sense that it tells them more than to communicate with others.¹¹

So, if living great and productive life is an art, facing honorable death is a courageous stride to get through this mortal world with dignity and divinity. What else one can say except “**If you do not understand death, you will never know life.**”

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Conflicts of interest

Authors declare that there is no conflict of interest.

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