Review of: "Conscientious objection to enforcing living wills: A conflict between beneficence and autonomy and a solution from Indian philosophy"

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Potential competing interests: No potential competing interests to declare.

Thank you for sharing your thoughts in this insightful paper. I would like to offer some reflections to stimulate further debate and suggest some possible changes to the paper. Having lectured on ethics in India, written about autonomy and consent, and advocated for the creation of clinical ethics committees in India and elsewhere, I have some appreciation of the context. I am grateful of the opportunity to share my thoughts and frame my remarks under various headings.

1. **The so-called four principles** – anyone who has worked with me will know that I am no fan of the four principles method of ethical analysis. It provides a framework for discussion but is of limited value when it comes to making real-life clinical decisions. The principles regularly conflict with one another, so this should come as no surprise, and I suggest that you downplay this part of your argument. Certainly, medical practice in India has long been paternalistic, but the tide is probably turning. For instance, while patient autonomy has limited validity in public hospitals where the throughput of patients is such that there is no opportunity for raising ethical issues with a patient, let alone the family, the concept of autonomy is still important. Ignoring the previously expressed wishes of a patient that have been articulated in a legally valid document runs contrary to the basic universal right to self-determination. Therefore, if it is not possible for care to be transferred speedily to another doctor because of conscientious objections towards taking a particular course of action, then patient wishes surely ought to prevail.
2. **Living wills** – I am less familiar with details of Indian law, but a brief comment about terminology might be useful to avoid ambiguity. For instance, the UK Mental Capacity Act (2005) makes provision for advanced refusal of treatment, but a patient cannot direct doctors to provide particular types of care at any point in the future. The idea of a living will is a largely American concept, and more clarity would be an advantage with regard to the different types of advanced directive.
3. **Ayurvedic texts** – these are interesting, and Ayurvedic medicine and philosophy certainly has much to offer. However, ethics is a matter of social mores, which change with time, to say nothing of rapid developments within medicine, and these points might be worth discussing.
4. **Training and education** – while the situation is slowly changing, few Indian medical schools provide basic training in medical ethics and law, which is worth a mention. With paternalism the norm, things will only really change if future doctors are trained to think about patient-centered care and given tools, for instance, to help them assess the risks, burdens and benefits and weigh up whatever courses of action might be available. Ethics is often a matter asking the right questions at the right time and finding a course of action that results in the least amount of harm, which last point

you clearly acknowledge.

5. **The Covid emergency** – during the period in question, the Indian health care system was under extreme pressure, and there is an element of paradox in debating this case viewed against the backdrop of people being turned away at hospital gates because of lack of oxygen and ITU beds. A little more context would be an advantage because these were such abnormal times.
6. **Ahimsa, dharma and kingship** – your discussion on these concepts is thoughtful, although does including kingship throw added light on these issues? It might just cause confusion in people's minds. Ahimsa and dharma, however, are useful ways of framing the debate, and it could be an advantage to give them *more* prominence, with *less* time spent discussing beneficence, non-maleficence, autonomy and justice.