Routledge
Taylor & Francis Group

Health Communication

ISSN: 1041-0236 (Print) 1532-7027 (Online) Journal homepage: www.tandfonline.com/journals/hhth20

Ventriloquial Sensemaking of End-of-Life Care and Graduate Medical Education: A Case Study from Abu Dhabi

Halah Ibrahim, Thana Harhara & Debalina Dutta

To cite this article: Halah Ibrahim, Thana Harhara & Debalina Dutta (23 Apr 2025): Ventriloquial Sensemaking of End-of-Life Care and Graduate Medical Education: A Case Study from Abu Dhabi, Health Communication, DOI: 10.1080/10410236.2025.2484508

To link to this article: https://doi.org/10.1080/10410236.2025.2484508

© 2025 The Author(s). Published with license by Taylor & Francis Group, LLC.

Published online: 23 Apr 2025.

Submit your article to this journal

Article views: 151

View related articles

View Crossmark data

Full Terms & Conditions of access and use can be found at
https://www.tandfonline.com/action/journalInformation?journalCode=hhth20

HEALTH COMMUNICATION
https://doi.org/10.1080/10410236.2025.2484508

Routledge
Taylor & Francis Group

OPEN ACCESS Check for updates

Ventriloquial Sensemaking of End-of-Life Care and Graduate Medical Education: A Case Study from Abu Dhabi

Halah Ibrahim [a], Thana Harhara [b], and Debalina Dutta [c]

[a]Department of Medicine, Khalifa University College of Medicine and Health Sciences; [b]Department of Medicine, Sheikh Khalifa Medical City; [c]Department of Communication Journalism and Marketing, Massey Business School

ABSTRACT
Previous research has emphasized the role of clinician-educators as providers of knowledge and expertise for medical trainees, centralizing the power of voice and agency in these interactions. Rhetoric of health and medicine encompass nuanced observations of health and medicine practices by foregrounding discourses contextualizing communication. These are particularly relevant for studying persuasive practices in health and medicine that identify challenging issues and decision-making by caregivers. In this case study from the United Arab Emirates, we argue through the lens of rhetorical ventriloquism that contextual factors play roles in shaping training discourses in physician-resident communication. Through analysis of 18 interviews, we found that when ambiguities prevail in the context of taken-for-granted training practices, cultural, social, and structural intersections emerge to stand in and shape the ways in which medical education around end-of-life care is constructed. Implications of the findings for the scholars, educators, trainers, and health practitioners are discussed.

Omilion-Hodges and Swords define palliative care as a "specialized type of medical care that anchors focus on improving patients' quality of life by providing relief and helping to alleviate the stress" (Omilion-Hodges & Swords, 2016, p. 1272). Early referral to palliative care services has been shown to mitigate pain and symptoms and improve the quality of life for patients and their caregivers while decreasing healthcare costs (Sleeman et al., 2019). Research has shown that medical trainees who receive formal education in palliative medicine (Centeno & Rodríguez-Núñez, 2015) display more confidence and professionalism in providing end-of-life care (Billings et al., 2010) and are more comfortable with essential decision-making in their practice (Pieters et al., 2019). Kraus et al. (2016) define end-of-life (EoL) care as a component of palliative care that is directed toward individuals "who are nearing the end-of-life" (p. ix). EoL care focuses on a short time period before death and includes decision-making around goals of care and medical management (Sagha Zadeh et al., 2018).

As the world's population ages and the prevalence of non-communicable diseases increases, physicians will need to develop the skills to manage terminally ill patients and their families. In response, educators globally have called for the development and implementation of medical curricula to better equip medical students and residents with the knowledge and skills to provide compassionate and culturally sensitive EoL care (Abel & Kellehear, 2018; Pieters et al., 2019). However, reviews of curricula from medical schools and residency programs worldwide reveal a fragmented and inconsistent approach to EoL training. These approaches include but are not limited to cultural perceptions around death and dying and the competence of physicians to align cultural sensitivities to their own training to provide EoL care (Ibrahim et al., 2022). Thus, potentially resulting in a future physician workforce that lacks the preparedness and expertise to adequately care for dying patients (Harhara & Ibrahim, 2021).

Prior studies from the patient's perspective reveal that communication is a major barrier to EoL care (de Vogel-Voogt et al., 2007). Clear and direct conversations around death are essential to ensure that treatment plans align with patient goals (Mack et al., 2010) and have been associated with improved patient outcomes and reduced intensity of care at the EoL (Jimenez et al., 2018). For caregivers and family members, these discussions may protect against complicated grief- prolonged grief associated with ongoing psychological, social, and physical impairment (Shear, 2015). Yet, physicians are often reluctant or feel poorly prepared to initiate conversations about death and dying (Shen & Wellman, 2019) and often underestimate patient and caregiver willingness and need for this information (Shen & Wellman, 2019). Research also shows that medical students and residents have limited exposure to EoL discussions and rarely participate in these conversations (Harhara & Ibrahim, 2021).

The existing literature has focused primarily on whether institutions offer EoL education for their trainees, with recommendations for curricular reform (Litauska et al., 2014). These simplistic supply and demand logics neglect many important dimensions of EoL training across diverse cultural contexts. This is particularly relevant in non-European settings, where medical education is tied to structures, the norms and rules governing medical institutions, and cultural contexts, referring to the values and meanings

CONTACT Debalina Dutta D.Dutta@massey.ac.nz Department of Communication Journalism and Marketing, Massey Business School, Business Studies Central BSC B1.06, Palmerston North 4442, New Zealand

© 2025 The Author(s). Published with license by Taylor & Francis Group, LLC.
This is an Open Access article distributed under the terms of the Creative Commons Attribution-NonCommercial-NoDerivatives License (http://creativecommons.org/licenses/by-nc-nd/4.0/), which permits non-commercial re-use, distribution, and reproduction in any medium, provided the original work is properly cited, and is not altered, transformed, or built upon in any way. The terms on which this article has been published allow the posting of the Accepted Manuscript in a repository by the author(s) or with their consent.

held within communities (Dutta et al., 2021, 2022). There are theoretical and practical implications for health communication scholars in exploring the sense-making processes and paradoxes in EoL communication education currently provided to medical trainees. While prior research has identified structural and pragmatic challenges in EoL care (Davidson et al., 2016), most studies are conducted in the Western setting, bringing into question the universality of such work. Moreover, when facing challenging situations in communicating uncomfortable topics, the pragmaticism and strategic communication of stakeholders can be applied to study similar issues in healthcare settings, particularly in the context of different cultural and structural challenges. In this study, we provide a case study of the perceptions and experiences of clinical faculty in an academic medical center in the United Arab Emirates (UAE) around EoL care and communication, delineating how this impacts medical trainee education. We use the lens of rhetoric in health and medicine (RHM) – to justify "recasting problems in health and medicine" (Segal, 2005, p. 1), detouring from the taken-for-granted assumptions about EoL care in Western medicine. For instance, combining human and non-human with rhetoric, Teston (2017) examined that for exploring treatment options, patient bodies become central to negotiations in medical practice. Kessler (2022) analyzed the role of stigma on gastrointestinal conditions and drew attention to the growing role of RHM scholarship on relations, interactions, and emotions. Thus, Burry and Melonçon (2024) maintain that for medical conditions that need histories, discussions, and stories, situating communication is fundamentally important to medical treatments and interventions. To that end, we aim to foreground rhetorical ventriloquism (Bivens, 2019) as phenomenological, communicative acts of calling upon structures, objects, and organizations, among others, to stand in to enact the vocal biddings of physicians for medical trainees in critical situations (Cooren, 2018).

The topic of EoL education is worthy of scholarly investigation for two main reasons. First, most EoL work assumes that physicians and medical trainees have had opportunities to receive formal training in developing their expertise through a structured EoL curriculum, thus drawing attention to the studies conducted in conventional, Anglocentric contexts where EoL care is prescriptive and legalized. The study findings will have implications for medical educators and students in specific cultural settings who do not have access to an endorsed set of structural norms around EoL care and need to improvise as they may not receive structural organizational training. In addition, scholars who are working toward understanding cultural taboos around difficult conversations around death and dying might find this relevant to their research. Second, resident physicians and their supervisors in the UAE have expressed uncertainty and tension around EoL communication with patients and their families (Harhara et al., 2024), which may have implications for quality EoL care. Therefore, the case can provide stakeholders, including policymakers, physicians, and trainees, with a better understanding of the rhetoric around the "everyday" EoL communication, refocusing attention to contextual factors that shape such interactions around imparting education to residents through the lens of ventriloquism (Bivens, 2019).

Case context: UAE

The UAE is a small, multicultural country in the Middle East. Individuals from over 200 nationalities live and work in the UAE (UAE Ministry of Foreign Affairs – MOFA, n.d.). With a population of approximately 9.6 million, Emiratis constitute only 11%, while the remaining 89% is comprised of expatriates from various parts of the world (UAE Ministry of Foreign Affairs - MOFA, n.d.). The healthcare system is also diverse, with most physicians originating from diverse geographic and educational backgrounds. This growing multicultural and multilingual workforce creates unique challenges for healthcare and medical education systems.

In recent decades, the region has experienced an aging population with an increase in noncommunicable and chronic diseases (Ibrahim et al., 2015, Nair et al., 2018). The World Health Organization (WHO) reports that over the next two decades, cancer incidence will likely double in the Middle East, with most malignancies diagnosed at relatively advanced stages (*WHO Eastern Mediterranean region noncommunicable diseases*, 2024). Consequently, the burden of serious health-related suffering is predicted to increase 170%, the highest proportional increase globally (Sleeman et al., 2019), making the need for palliative and EoL care in the UAE a public health priority. However, palliative medicine is underdeveloped in the region. Most EoL care is provided in acute hospital settings, primarily by nonspecialist physicians and medical trainees.

Despite this urgent need, EoL care is not routinely taught in UAE medical schools and residency programs, with limited structured clinical exposure, leaving trainees feeling uncomfortable and unprepared for these tasks (Harhara & Ibrahim, 2021; Ibrahim & Harhara, 2022a). Moreover, clinical faculty express multiple barriers to teaching EoL care, including cultural and religious concerns (Harhara & Ibrahim, 2021; Ibrahim & Harhara, 2022b). There is also a paucity of published literature on EoL communication from the Middle East perspective. Healthcare professionals in the region have historically believed that talking openly about death may be incongruous with patient and family cultural and religious practices and can be considered disrespectful because of the belief that only God can determine one's fate (Ibrahim & Harhara, 2022b). As a result, physicians may not openly discuss terminal prognoses with patients (Ibrahim & Harhara, 2022d). However, emerging attitudes and patterns in the region note a preference for direct and honest communication over benevolent deception strategies (Ibrahim & Harhara, 2022c). Research has also shown that the advancement of EoL care requires embedding this education into medical training (Mason et al., 2020). Therefore, improving care for terminally ill patients and their families will require a deeper understanding of the challenges physicians face in providing and teaching EoL communication.

Literature review

Ventriloquism as a theoretical lens

We use rhetorical ventriloquism to describe how physicians in an academic medical center in the UAE make sense of EoL care and the pathways that circumvent the traditional meaning-making tropes in structured medical education. Ventriloquism is the creation of an illusion in which a person pretends that a prop

possesses a "voice" (Cooren & Sandler, 2014). Akin to how ventriloquists make their dummy/figure "do" something, we aim to understand how educators draw upon ideologies, concepts, or objects to communicate the importance and skills of EoL communication to their residents so that the "silence" around EoL care is addressed. Given Cooren's (2020) contention that "everything can speak," foregrounding rhetoric as a communicative act, we analyze how and to whom the educators turn when they, themselves, feel unprepared and unable to communicate EoL care instructions and guidance to medical trainees. Costantini and Wolfe (2022) note "as ventriloquist and figure (as many ventriloquists refer to their dummies) interact, they animate each other; it is precisely their relationship of attachment, their connections, and interdependence with one another that allow them to speak simultaneously as distinct figures and as a collective" (p. 3). The apparent dissociation and relocation of voice and agency, as seen in the interaction between the ventriloquist and the figure, reifies the transference of power and communication in interactions between the living and the non-living in a particular environment. Studies have sought to understand the role of ventriloquism in health communication, with Bivens, (2019) noting that audioscapes, or sounds and noises, in neonatal intensive care units contribute to understanding the quality of communication among stakeholders. Ventriloquism has been explored further in physician-patient communication (Carter, 2002; Guo et al., 2014). For example, Carter (2002) describes a form of adult-child ventriloquism during clinical encounters with children with chronic pain, in which the physicians direct all their questions to the parents instead of the children. In a study of Chinese women giving birth in New Zealand, Guo et al. (2014) explain how the mother's voice is often absent or presented through a professional filter, or professional ventriloquism, whereby the mother's words and actions were often interpreted through the midwife's Western experiences, ideologies, and medical assumptions.

Ventriloquism offers an important lens to examine how cultural and structural constraints shape how physicians teach students to communicate with dying patients and their families. Extant research shows that dying and death often remain a taboo topic with patients and their physicians (Wise, 2012), with ambivalence around expert opinions on dealing with the EoL (Kremeike et al., 2021). Therefore, our study offers insights into the experiences of clinician-educators in the UAE in their efforts to teach medical trainees EoL communication.

Methods

From December 2019 to March 2020, we conducted one-on-one interviews with physicians in a large teaching hospital in the UAE to better understand their experiences in teaching EoL communication and care to medical trainees. The study was approved by the Sheikh Khalifa Medical City institutional review board in Abu Dhabi, UAE [RS-564]. We used the consolidated criteria for reporting qualitative studies (COREQ) framework to guide methodology and reporting (Tong et al., 2007).

Interview guide

The interview guide was developed by two of the authors, who have formal training and experience in palliative care (TH) and medical education (HI, TH). Semi-structured interview questions were developed to gain a deeper understanding of physicians' comfort level and experiences in teaching EoL care principles to medical trainees, barriers to education, and how prior training and experiences impacted their current teaching. The interview guide was piloted on two clinician educators in affiliated teaching hospitals and was adjusted for length and comprehension based on their feedback. These interviews were not included in the data analysis. Adjustments to interview questions were made as the semi-structured interviews progressed.

Setting and participants

Participants in this study included physicians from an academic medical center in the UAE. The hospital serves as a regional oncology referral center and a safety net hospital, serving patients of all socioeconomic levels, regardless of insurance status. It is also the largest provider of postgraduate medical education in the country, sponsoring 268 trainees across internship, residency, and fellowship training.

Interviews

A Purposeful sampling strategy was used (Tracy, 2024). In December 2019, e-mails explaining the study background and purpose were sent to all teaching physicians in general internal medicine, critical care, hematology, and oncology departments in a large teaching hospital in the UAE ($n = 22$). These specialties were selected because they provide palliative and EoL care to hospitalized patients and are involved in the medical training of physicians from multiple disciplines, including internal medicine, family practice, and emergency medicine. Participation was voluntary, and no incentives were provided. After providing verbal and written informed consent, respondents participated in one-to-one semi-structured interviews with one of the investigators (HI, TH). All interviews were conducted in person in English using vacant offices to ensure privacy. Interviews lasted 30–45 minutes and were audio-recorded. No additional notes were taken. The recordings were transcribed by professional transcriptionists and de-identified, except for specialty. Data collection and analysis occurred concurrently. We planned that when the research team was confident that saturation was reached, two additional interviews would be conducted to ensure that no new themes arose. We thereby continued conducting semi-structured interviews until we obtained three consecutive interviews with data saturation, resulting in 18 interviews.

Data analysis

The transcribed interviews were crosschecked for accuracy against the audiotapes and open-coded by all three authors. The codes were then arranged based on emerging themes that helped us identify sequences or instances where we noted shifting from human to non-human agency. References to culture, training, prior experiences, and anticipatory practices were assessed against the criteria of repetition and reoccurrence (Tracy, 2024). The commonly occurring themes were collated and quotes were then chosen to best represent the themes. The authors met regularly and discussed the themes for clarity and agreement, leading to

researcher triangulation. The themes were finalized when the authors agreed via discussion and deliberation.

Results

The 18 physicians interviewed represented different specialties and educational backgrounds, as well as different ethnicities, cultures, and religions. Participant demographic characteristics are listed in Table 1. Upon analysis, we found four themes centered around physician experiences teaching EoL communication to medical trainees in the UAE. We present the four themes below.

Sensemaking of training policies and challenges

In this theme, the physicians refer to the lack of structured education and curricula in EoL communication and care. All the physicians interviewed agree that EoL education is needed. They refer to the training in EoL care as a tangible, agentic resource or policy that can improve the quality of patient care in the country, thus consequently muting their own roles as educators in imparting the training or in developing the policies. The rhetoric of physician belief systems around training, experience, and discussion with residents has specific outcomes of EoL care. For example, one physician stated: "I'm a very strong believer that they [residents] should be trained and should be comfortable in making end-of-life decisions and having those conversations. It is mandatory, actually ... This is what we require ... This is what reduces anxiety." In this excerpt, we note the physician's advocacy for having conversations around EoL. We also note that instead of drawing upon his teaching expertise, the physician emphasizes the importance of training as a mandatory policy to help the residents engage in future conversations with their patients. Some physicians also highlighted the residents' agency in the process. As another participant noted "It should be initiated from the residents' end, because they always think that they are still on the learning pattern, and it will be difficult for them. But I think it should be physician, specialist, nursing ... everyone involved should be there to make it ok for people to discuss it."

Others discussed the need for policies for training not only the residents but also the faculty, given the lack of clear mandates around EoL care. As one educator succinctly recalled, "If you don't have a practice policy, you cannot just teach. Then, they [residents] will not practice ... Most of the time, if I am there, they will go in the shadows so they will not initiate the discussions." These conversations highlight the physicians' desire for the necessary curriculum and the involvement and cooperation of all stakeholders to teach EoL communication, thereby minimizing personal responsibility. The physicians also draw upon how both faculty members and residents need to be trained with a curriculum that embraces teaching and learning in the local context while noting the current issues that might prevent them and the residents from doing so. Adding to these training discourses are the parallels that some participants draw by using their personal experiences to address the limited palliative care training in the hospital without bringing attention to themselves as human resources for teaching. These excerpts offer sense-making of the existing education and heavy reliance on those teaching resources without bringing into focus their own active role as educators. We note the distancing of their own opinions and expertise of EoL education and the focus on existing training, or lack thereof, highlighting how EoL should be taught by adopting a voice other than their own.

Table 1. Physician demographics ($N = 18$).

Demographic Characteristic	Number of physicians (%N)
Gender	
Male	13 (72%)
Female	5 (28%)
Specialty	
Internal Medicine	8 (45%)
Critical Care	4 (22%)
Hematology/Oncology	6 (33%)
Ethnicity	
African	1 (6%)
Arab	8 (44%)
Asian	8 (44%)
European	1 (6%)
Religion	
Muslim	12 (66%)
Christian	2 (11%)
Hindu	3 (17%)
None	1 (6%)

Structural practices

As a theme, structural practices constitute the collective of rules, regulations, policies, and the everyday organizational practices of the teaching hospital in which EoL medical education is undertaken. In this theme, we note the participants' understanding and sense-making of the same including the training policies discussed in the earlier theme. We differentiate the two from the viewpoint of the physicians who consider teaching resources as independent from all other structural resources. It is explained by the educators as how normal activities are carried out and the interactions and expectations of physicians and trainees around EoL discourse. By recognizing the limits and roles of such structural practices in patient management, the physicians make sense of the shortcomings of existing practices of the organization and offer interpretations that appear disembodied and/or fractured from their opinions, but are their opinions, nevertheless that stand in substitution rhetorically. These paradoxical interpretations offer alternate ways of critiquing the existing structural practices. They draw upon these structures as living and able to influence how EoL communication is taught. Simultaneously, they work within these structures to deliver the education without being overtly visible, intentionally or unintentionally. The physicians note the existing structures as challenging to the teaching of EoL communication. For example, one physician brings up the inadequacies in structural practices regarding patient death in the local setting, as compared to his country of training. He offers the example of Morbidity and Mortality meetings, which circumscribe the EoL practices that should be taught and followed as standard practices from the Western perspective.

> Referring to the UK, we used to discuss all the mortalities, and that's how we used to debrief it. We used to have this monthly mortality meeting for all the stroke patients in an open environment with everybody around. Here, how we do the...mortality meetings is very different.

Other physicians offer explanations for the lack of structural resources, which creates issues in teaching EoL care. The

structural resources, including multidisciplinary teams and palliative care trained specialists, are considered central to teaching residents, and the lack of these resources is often highlighted.

> I think we don't have enough expertise in the system to deal with this [EoL care]. I don't think we have the team that takes care of all the aspects. Because if you want to teach this, you need the whole team here, like social workers, case managers, psychologists, counselors, the nurses, the spiritual leader – everyone needs to be on one team together, to make it easier for us to deliver this kind of service.

In the above quote, the physician notes the lack of structural resources as a reason for not teaching EoL communication and care. The physician refers to the lack of expertise or building up of structural resources, like multi-specialty teams, to provide EoL care. The deflection to other systems removes the physician's need to actively get involved in providing the same expertise to make up for what is lacking. Other physicians, however, explained how existing structures offered opportunities. Some educators discussed the ways in which they used structural everyday practices, such as family meetings, to help residents gain experience. One physician elaborated:

> They [the residents] sit with me. They come with me as I counsel. . .. each patient that I see. . .That's how they learn the concepts of EoL communication. I have never given a didactic talk about it. But what I normally do is, I get our team members to sit with me when I'm talking to the patients so that they see the interaction.

In the above quote, the physician centers the important structural role of didactic talks or teaching instructions that guide and orient the medical students toward the teacher-focused method of imparting knowledge and instructions on EoL communication. In the absence of specifics around existing instruction or teaching, she uses another voice of patient counseling to guide the medical students to help them learn EoL communication. The circumscribing of the standardized didactic lectures, which are not available in the context of the existing structural practices, to patient communication becomes the alternate medium of communicating EoL care. The structural requirement of counseling patients becomes an opportunity for the physician to teach EoL communication, substituting her role as an educator for that of existing structural practices.

Cultural practices

The cultural practices of the UAE were important factors in EoL communication, especially from the rhetoric of bodies and their connection to rites, customs, rituals, and ethics. In the collectivist society of the UAE, the extended family plays a major role in decision-making and disclosing information, with families often believing that concealing the truth about a terminal illness is more ethical and compassionate (Khalil, 2013). Without these goals-of-care conversations, physicians are unable to tailor treatments to align with patients' values and priorities, frequently resulting in increased intensity of care at the end-of-life. The physicians reference the norms and practices of the country that shape how communication about death and dying is perceived and addressed. The participants highlight the residents' positions as upholders of the cultural expectations surrounding death and the understanding of appropriate normative practices to follow, especially when communicating with patient families. One of the educators explained:

> One thing I felt here in this country was that every patient was an ICU (intensive care unit) candidate. Why would you take somebody who is going to die and make their last few weeks of life so torturous with what we do in the ICU? It was never designed for that purpose. Imagine that situation and then others who feel it's wrong not to do CPR (cardiopulmonary resuscitation)? A couple of residents, especially when I first came, said to me "you have to do it [CPR]; it's everybody's right." . . . In a DNR (do not resuscitate) situation, one of the residents was saying "Don't leave me. I don't know what to do with this- like all the patients go to ICU, I don't know what to do," And she was really afraid . . . because there was no CPR ongoing, she felt there was nothing to be said or done.

In the above quote, we note the agentic understanding of culture as an important signifier of how EoL communication is discursively constructed and understood. The physician notes the uncertainties around teaching EoL communication skills and goals of care conversations because of the cultural expectation that all life-prolonging treatments would be offered without considering the efficacy of such management. Another physician highlights that EoL teaching in the Western context is not relevant or adaptable locally. He reflects: "This is a culture issue and we have to understand that culture is very strong, and to dismiss it [culture] would be wrong. So, I think we have to tread this very carefully. I think it would be wrong for us to implement U.S. thought processes, you know Western ideas, completely here. It may not work." In this admission, the physician emphasizes the importance of culture in EoL care, where the role of the educator is minimized. This happens through experiential learning when the resident recognizes and respects the cultural nuances of EoL care without any teaching cues provided by the educator, but rather through sense-making and experience. As one physician described when asked about cultural practices related to teaching EoL care: "Sometimes I go with the resident. So, I think they like my way of communicating . . . I tell the truth but in a different way. We are in the Middle East and we should have our own way of telling the bad or breaking bad news." The participant describes a complex phenomenon whereby physicians may choose to communicate indirectly to suit the cultural preferences of patients and their families, using metaphors, analogies, or symbols to convey the seriousness of the situation without directly stating it. Moreover, maintaining hope is crucial in many Middle Eastern cultures. Physicians often convey hope and optimism to help patients and families cope with the diagnosis.

Another physician shared how reminding the trainees of culture as an everyday practice of EoL communication helped him reach out to his residents.

> When I do rounds with the residents, I will tell them that this patient is . . . 88 years old coming with possible cancer. What are we going to do even if we diagnose cancer? The patient will not tolerate surgery. But then you have to run it by the patient, by the family, and try to convince them not to be aggressive. But at the end, after that, they say I want everything to be done. Then I have to do it unless I get some clear instruction otherwise.

In the above quote, the educator places the normative ideals of EoL care via familial negotiations that the students themselves are advised to do in order to make appropriate treatment decisions. The quote further highlights the reference to the family who wants

to control the cultural narrative of dying by convincing the physician to increase the treatment intensity for the patient despite the advanced age and terminal cancer. The meaning-making centered around the expectations of death and dying to weigh heavily toward the expected cultural norms and the absence of EoL training and clearly set up directives that affect the physician's judgment and call to action at that moment. In this case, the educators defer to cultural practices as teaching resources for the residents to learn about EoL communication and management.

Immersive anticipatory practices

All the physicians noted the futility of imposing a Western curriculum in the local context, particularly regarding EoL communication skills. However, the existing structural and cultural considerations around death and dying were challenging, and the physicians were either unaware of the policies or unclear about how to implement them. The educators shared their struggle to teach EoL communication and care to the residents. Yet, they shared their anticipation and plans to teach, should the option be made available to them through pathways of shared and negotiated meanings and goals around EoL education. As one of the physicians note:

> The residents listen to the conversations with patients, but teaching, no we don't do this because, I don't know. I don't want to say that I gave up on this here, but it's really difficult. There is no way they [the patients] will accept it. I tried it many times, but I don't remember any case that turned out well with me . . . I don't know if somebody else has been able to convince a family to make a decision about end-of-life. So, this is why I was thinking, what would be the solution for this problem here? So, I think the best will be in the community- education, in the media, sometimes talking about palliative care, or medical lectures or something on TV.

In the above conversation, the physician shares the futility of formal training on this topic as it is in dissonance with existing cultural practices around death and dying. Instead, the physician recommends that there should be community awareness through public health messaging about palliative and EoL care principles in the media. The quote offers an anticipatory counterargument to setting up clear EOL guidelines when working with patients and their families to address the community. Another physician discussed the development of a palliative care teaching service as an anticipatory teaching resource. He stated:

> Initially, I think we can start by having a teaching service. We have to create the service itself first because somebody has to own it. You may be here; I could be here today, or maybe we would be on vacation for a month or so. We need to have a service first, that's covered and staffed 24/7. I think if you create the service, the teaching resources will be excellent. I think at some point, we have to include it in the core lectures that we have in the ICU. I think we should.

As noted in the above response, the physician points to the initial need to build the infrastructure for education. The anticipatory nature of the infrastructure is meant as a "suggestion" and a "thought," and, thereby, by posing their thoughts in this manner, the physician does not exercise their direct reference to their expertise. Rather than putting forward their informed opinion, they appear to digress on their knowledge and appear unsure as if speaking in two voices. Another physician notes, "I don't expect barriers in the implementation as long as we involve the right people and we educate the right people so that they see why it is important to implement this end-of-life curriculum."

Another physician minimized the reliance on lectures or reading materials, which emphasizes the educator's role. Instead, he felt that the residents should focus on the patient's experience and feelings, particularly when facing a high likelihood of treatment failure in cancer management. The physician maintains that the "first thing is to recognize that in patients with advanced cancer, failure is possible. Okay and then to probably address the approach for advance care planning at the beginning when they are diagnosed with cancer. In addition to that, the other things will be they [the residents] should have, rather than lectures or reading materials, they should have an objective role play."

The quote refers to the importance of role play, or consideration of the patient's situation, to help the resident work out a better EoL communication strategy, which attends to the anticipatory immersive practices as outlined by the physicians interviewed. By suggesting role-playing EoL communication as an anticipatory practice, the physician takes the focus away from the current need for didactics and physician-led teaching.

Discussion

In this case study conducted in UAE, we looked at the meaning-making practices of physicians, using the lens of rhetorical ventriloquism, to clarify and explain how these phenomenological interactions shape the discourses of ethos of EoL communication and care to their residents. We examined the communicative everyday acts related to EoL education, which although essential for medical trainees, can be embedded in structural and cultural contradictions around the rhetoric of death and dying. We looked at the four themes that emerged from the interviews of physicians who work closely with residents in providing support for seriously ill patients. We also revealed how the participants circumvent their own roles as educators in favor of other resources (or props) for EoL training, thus muting their own voices as experts, constraining their position in a cultural imbrication of values, norms, and practices within UAE health systems and of EoL care. This is in congruence with Cooren's (2018) theorization of ventriloquism as fundamentally rhetoric foregrounding the role of policies and ideologies, speaking in the name of personal expertise and training that forms the basis of professional identities that bode respect for physicians when training residents to communicate EoL to stakeholders. In this regard, the physicians distract from not fulfilling their responsibilities and expectations as educators by making other factors stand in that impact and impede the training- a sort of educational ventriloquism that centers rhetoric as a tensional process to acknowledge and simultaneosly disrupt established organizational norms around EoL scripts. In addition, our study contributes to the theoretical understanding of ventriloquism by suggesting the agentic role of the medical trainees themselves in realizing the value of training as discussed by the educators, particularly when standardized teaching practices and syllabi are not available, highlighting the importance of multiple voices attending to the embodied meaning-making in EoL medical education in the context of the UAE, thus foregrounding phenomenological experiences in amplification of such voices (Bivens, 2019). We also note the "silent structural and cultural" context standing in and amplifying the messages from the

physicians to the medical trainees, especially when EoL scripts remain absent in healthcare systems in Abu Dhabi.

In addition, the study points to the role of educational policy frameworks around EoL communication and patient care and the ways in which these policy frameworks are situated amidst the complexities of cultural and structural contexts. The physicians often refer to science-based Western biomedicine as the dominant healthcare paradigm globally. Simultaneously, they recognized the potential to integrate holistic end-of-life approaches to better align with the needs of dying patients. Outside of the Western models of communication training, developed within the dominant context of the United States, the physicians negotiated the challenges of not having clear, culturally, and structurally grounded guidelines for understanding and operationalizing the training. Our findings support earlier research about the challenges associated with EoL communication in the Middle East (Harhara & Ibrahim, 2021). Our results are also consistent with other studies in non-Western settings. For example, a study of physicians practicing in Japan, Korea, and Taiwan showed that more than half reported that families often preferred to avoid EoL discussions with the healthcare team (Cheng et al., 2015). The absence of a clear communication framework results in ambiguities in training. Although the physicians note the importance of developing a framework for training, they simultaneously point to the lack of an existing one. This results in recognition of the need to educate both faculty and residents in EoL communication. However, instead of referring to their expertise in reorganizing and arranging training discourses, the physicians offer alternate realities and foreground the structural, cultural, and future planning resources needed to provide concrete education to the residents. Note here the paradoxes such ventriloquial articulations have on the logic of taken-for-granted assumptions on the residents' own agency in seeking such training. We also found that the physicians as educators and residents as students willing to learn model is challenged by the physicians' own perceptions that residents might be unaware or unwilling to engage in EoL communication. Taken together with the understanding that communication is important and paramount to providing quality healthcare, this finding may have profound implications for medical education and patient care.

Furthermore, the structural contexts of the healthcare organization shape the teaching of EoL communication. Particularly salient are the roles, rules, policies, and norms within healthcare. The lack of locally relevant structural frameworks for serious illness discussions limits the possibilities for education and training in EoL communication. The lack of knowledge or implementation of policy frameworks that inform EoL communication results in gaps in education, with physicians often experiencing uncertainty and discomfort regarding what and how to communicate. Moreover, the structural contexts of the healthcare organization are shaped by the limited resources dedicated to EoL care, which also contribute to the uncertainties that physicians face when training residents.

Moreover, the existing cultural rhetoric in a context plays a key role in shaping EoL communication and education. The physicians note that the dominant framework is Western-centric, largely informed by education programs developed in the United States. They recognize the limits of this framework in the cultural context of the Middle East, as the conversations around death and dying are familial decisions rooted in doing and trying everything for the patient, which is in tension with the "do not resuscitate" guidelines, further highlighting the need for culturally informed EoL education programs. In the absence of locally relevant frameworks, they often avoid the topic altogether, while "animating" props as excuses to detract from this important issue, as Cooren (2018) explained as dislocation that becomes rhetorically mobilized in those interactions with graduate student. In this regard, they highlight the importance of developing experiential frameworks that are rooted in cultural contexts of Abu Dhabi.

Although our findings reflect a growing recognition of the importance of EoL education in improving the quality of life for patients and their families, there is also an acknowledgment of prevailing assumptions that the finite nature of EoL care might limit its impact and potentially dilute justifications for the widespread implementation of EoL policies and programs. These assumptions can negatively impact the sustainability of EoL training. Recent studies are working toward sustainability through continuous education and training. They are also advocating for integrated care models that incorporate EoL into standard practice, institutional policies supporting funding and resource allocation, and increased public awareness and acceptance of EoL care to drive the policy changes that will enhance sustainability.

Finally, in the absence of existing structural resources, participants discuss anticipatory practices. They note that opportunities for educating residents often emerge from the everyday experiences of communication with hospitalized patients. Building sustained structures for education is critical, and they suggest that their everyday practices form a basis for creating these curricula and policies. Thus, it highlighted how complexities get played out in negotiating the experiences of EoL communication between medical educators and trainee physicians in the UAE. One such complexity is the role of emotional labor – especially in the moments of vulnerability that are integral in these EoL discourses but often difficult to parse out in the rhetorical sensemaking. We note how rhetorical ventriloquism offers opportunities and imbricates "failure" as a device to justify the decisions underlying EoL communication through the tensional interplay of avoidance to confront EoL decisions and communicate the right messages to the patients and their families to enable them to make informed decisions. The rhetoric of failure is communicated through suggestions of the use of metaphors, stories, and existing examples that suggest mitigation of aggression to save patients' lives, which is deemed unnecessary and would cause distress to a dying patient. The constraints and dilemmas associated with taboos around EoL are dissociated and often absent in Western medical education on the topic and when viewed through the lens of rhetorical ventriloquism. The taboo versus disclosure mechanisms of rhetoric around EoL teaching and learning embodying structural and cultural contexts have implications for medical students, trainees, and health policymakers in similar contexts.

Limitations

This research has several limitations. For instance, we only sought the opinion of the teaching physicians and the approach to EoL care education is based upon their own views. Future studies could investigate residents' perspectives of palliative care education and their lived experiences of providing EoL care. Further research on patients' needs and expectations regarding serious illness communication and decision-making is also needed. Including these perspectives in understanding the teaching of EoL communication is critical to our holistic understanding of this important topic. Finally, the interviews were conducted by colleagues known to the physicians. Although we believe that this helped encourage openness and engagement around a sensitive topic, it may have also biased the responses.

Disclosure statement

No potential conflict of interest was reported by the author(s).

ORCID

Halah Ibrahim http://orcid.org/0000-0002-9240-7726

Ethical approval

This study was approved by the Sheikh Khalifa Medical City Research Ethics Committee [approval number RS-564]. All participants signed written informed consent prior to participation.

References

Abel, J., & Kellehear, A. (2018). Palliative curriculum re-imagined: A critical evaluation of the UK palliative medicine syllabus. *Palliative Care*, *11*, 11. https://doi.org/10.1177/1178224218780375

Billings, M. E., Engelberg, R., Curtis, J. R., Block, S., & Sullivan, A. M. (2010). Determinants of medical students' perceived preparation to perform end-of-life care, quality of end-of-life care education, and attitudes toward end-of-life care. *Journal of Palliative Medicine*, *13*(3), 319–326. https://doi.org/10.1089/JPM.2009.0293

Bivens, K. M. (2019). A Neonatal Intensive Care Unit (NICU) soundscape: Physiological monitors, rhetorical ventriloquism, and earwitnessing. *Rhetoric of Health & Medicine*, *2*(1), 1–32. https://doi.org/10.5744/RHM.2019.1001

Burry, J., & Melonçon, L. (2024,). Rhetoric of health and medicine. In M. Power (Ed.), *Oxford research encyclopedia of communication*. Oxford. https://oxfordre.com/communication/view/10.1093/acrefore/9780190228613.001.0001/acrefore-9780190228613-e-1442

Carter, B. (2002). Chronic pain in childhood and the medical encounter: Professional ventriloquism and hidden voices. *The Qualitative Health Research*, *12*(1), 28–41. https://doi.org/10.1177/104973230201200103

Centeno, C., & Rodríguez-Núñez, A. (2015). The contribution of undergraduate palliative care education: Does it influence the clinical patient's care? *Current Opinion in Supportive and Palliative Care*, *9*(4), 375–391. https://doi.org/10.1097/SPC.0000000000000169

Cheng, S. Y., Suh, S. Y., Morita, T., Oyama, Y., Chiu, T. Y., Koh, S. J., Kim, H. S., Hwang, S. J., Yoshie, T., & Tsuneto, S. (2015). A cross-cultural study on behaviors when death is approaching in East Asian Countries: What are the physician-perceived common beliefs and practices? *Medicine*, *94*(39), e1573. https://doi.org/10.1097/MD.0000000000001573

Cooren, F. (2018). Materializing communication: Making the case for a relational ontology. *Journal of Communication*, *68*(2), 278–288. https://doi.org/10.1093/JOC/JQX014

Cooren, F. (2020). Beyond entanglement: (Socio-) materiality and organization studies. *Organizaton Theory*, *1*(3). https://doi.org/10.1177/2631787720954444

Cooren, F., & Sandler, S. (2014). Polyphony, ventriloquism, and constitution: In dialogue with Bakhtin. *Communication Theory*, *24*(3), 225–244. https://doi.org/10.1111/COMT.12041

Costantini, R. A., & Wolfe, A. W. (2022). Authorial incongruity and organizational presence(s): A ventriloquial analysis of shadowed organization. *Management Communication Quarterly*, *36*(4), 612–636. https://doi.org/10.1177/08933189221076853

Davidson, P. M., Phillips, J. L., Dennison-Himmelfarb, C., Thompson, S. C., Luckett, T., & Currow, D. C. (2016). Providing palliative care for cardiovascular disease from a perspective of sociocultural diversity: A global view. *Current Opinion in Supportive and Palliative Care*, *10*(1), 11–17. https://doi.org/10.1097/SPC.0000000000000188

de Vogel-Voogt, E., van der Heide, A., van Leeuwen, A. F., Visser, A. P., van der Rijt, C. C. D., & van der Maas, P. J. (2007). Patient evaluation of end-of-life care. *Palliative Medicine*, *21*(3), 243–248. https://doi.org/10.1177/0269216307077352

Dutta, D., Ibrahim, H., Stadler, D. J., Cofrancesco, J., Nair, S. C., & Archuleta, S. (2021). International residency program directors on implementing educational transformation: A qualitative study of their experiences and strategies for overcoming challenges. *Journal of Graduate Medical Education*, *13*(4), 526. https://doi.org/10.4300/JGME-D-21-00050.1

Dutta, D., Stadler, D. J., Cofrancesco, J., Archuleta, S., & Ibrahim, H. (2022). "I find it quite a privilege to be involved in their lives": A multinational qualitative study of program directors' perspectives on their relationships with residents. *Teaching and Learning in Medicine*, *34*(5), 473–480. https://doi.org/10.1080/10401334.2021.1997749

Harhara, T., Buhumaid, R., Oyoun Alsoud, L., & Ibrahim, H. (2024). Palliative care education: A nationwide qualitative study of emergency medicine residency program directors in the United Arab Emirates. *International Journal of Emergency Medicine*, *7*(1), 1–10. https://doi.org/10.1186/S12245-024-00643-Z

Harhara, T., & Ibrahim, H. (2021). Undergraduate palliative care education in the United Arab Emirates: A nationwide assessment of medical school deans. *BMC Medical Education*, *21*(1), 1–8. https://doi.org/10.1186/s12909-021-02966-4

Ibrahim, H., Awadhi, A., Al Shaban, S., & Nair, S. C. (2015). Can our residents carry the weight of the obesity crisis? A mixed methods study. *Obesity Research & Clinical Practice*, *9*(3), 228–233. https://doi.org/10.1016/J.ORCP.2014.09.004

Ibrahim, H., & Harhara, T. (2022a). How internal medicine residents deal with death and dying: A qualitative study of transformational learning and growth. *Journal of General Internal Medicine*, *37*(13), 3404–3410. https://doi.org/10.1007/S11606-022-07441-4

Ibrahim, H., & Harhara, T. (2022b). Palliative care training: A national study of internal medicine residency program directors in the United Arab Emirates. *BMC Palliative Care*, *21*(1), 1–7. https://doi.org/10.1186/s12904-022-00935-2

Ibrahim, H., & Harhara, T. (2022c). Perceptions of a good death in a Middle East Country. *Journal of Pain and Symptom Management*, *63*(5), e567–e569. https://doi.org/10.1016/j.jpainsymman.2022.01.019

Ibrahim, H., & Harhara, T. (2022d). Truth disclosure at the end of life: A qualitative study of internal medicine residents in the United Arab Emirates. *American Journal of Hospice & Palliative Medicine®*, *39*(10), 1182–1187. https://doi.org/10.1177/10499091211063820

Ibrahim, H., Lootah, S., Satish, K. P., & Harhara, T. (2022). Medical student experiences and perceptions of palliative care in a middle eastern country. *BMC Medical Education*, *22*(1). https://doi.org/10.1186/S12909-022-03448-X

Jimenez, G., Tan, W. S., Virk, A. K., Low, C. K., Car, J., & Ho, A. H. Y. (2018). Overview of systematic reviews of advance care planning: Summary of evidence and global lessons. *Journal of Pain and Symptom Management*, *56*(3), 436–459.e25. https://doi.org/10.1016/J.JPAINSYMMAN.2018.05.016

Kessler, M. M. (2022). *Stigma stories: Rhetoric, lived experience, and chronic illness*. Ohio State University Press.

Khalil, R. B. (2013). Attitudes, beliefs and perceptions regarding truth disclosure of cancer-related information in the Middle East: A review. *Palliative & Supportive Care*, *11*(1), 69–78. https://doi.org/10.1017/S1478951512000107

Kraus, C. K., Greenberg, M. R., Ray, D. E., & Dy, S. M. (2016). Palliative care education in emergency medicine residency training: A survey of program directors, associate program directors, and assistant program directors. *Journal of Pain and Symptom Management*, *51*(5), 898–906. https://doi.org/10.1016/J.JPAINSYMMAN.2015.12.334

Kremeike, K., Dojan, T., Rosendahl, C., Junger, S., Romotzky, V., Bostrom, K., Frerich, G., & Voltz, R. (2021). "Withstanding ambivalence is of particular importance"—Controversies among experts on dealing with desire to die in palliative care. *PLOS ONE*, *16*(9), e0257382. https://doi.org/10.1371/JOURNAL.PONE.0257382

Litauska, A. M., Kozikowski, A., Nouryan, C. N., Kline, M., Pekmezaris, R., & Wolf-Klein, G. (2014). Do residents need end-of-life care training? *Palliative & Supportive Care*, *12*(3), 195–201. https://doi.org/10.1017/S1478951512001101

Mack, J. W., Weeks, J. C., Wright, A. A., Block, S. D., & Prigerson, H. G. (2010). End-of-life discussions, goal attainment, and distress at the end of life: Predictors and outcomes of receipt of care consistent with preferences. *Journal of Clinical Oncology*, *28*(7), 1203. https://doi.org/10.1200/JCO.2009.25.4672

Mason, S., Paal, P., Elsner, F., Payne, C., Ling, J., Noguera, A., & Mosoiu, D. (2020). Palliative care for all: An international health education challenge. *Palliative & Supportive Care*, *18*(6), 760–762. https://doi.org/10.1017/S1478951520000188

Guo, S. (P.), Munshi, D., Cockburn-Wootten, C., & Simpson, M. (2014). Cultural dilemmas of choice: Deconstructing consumer choice in health communication between maternity-care providers and ethnic Chinese mothers in New Zealand. *Health Communication*, *29*(10), 1020–1028. https://doi.org/10.1080/10410236.2013.831515

Nair, S. C., Jaafar, H., Jaloudi, M., Qawasmeh, K., AlMarar, A., & Ibrahim, H. (2018). Supportive care needs of multicultural patients with cancer in the United Arab Emirates. *Ecancer*, *12*. https://doi.org/10.3332/ECANCER.2018.838

Omilion-Hodges, L. M., & Swords, N. M. (2016). Communication that heals: Mindful communication practices from palliative care. *Health Communication*, *31*(3), 328–355. https://doi.org/10.1080/10410236.2016.1219928

Pieters, J., Dolmans, D. H. J. M., Verstegen, D. M. L., Warmenhoven, F. C., Courtens, A. M., & Van Den Beuken-Van Everdingen, M. H. J. (2019). Palliative care education in the undergraduate medical curricula: Students' views on the importance of, their confidence in, and knowledge of palliative care. *BMC Palliative Care*, *18*(1). https://doi.org/10.1186/S12904-019-0458-X

Sagha Zadeh, R., Eshelman, P., Setla, J., & Sadatsafavi, H. (2018). Strategies to improve quality of life at the end of life: Interdisciplinary team perspectives. *The American Journal of Hospice & Palliative Care*, *35*(3), 411–416. https://doi.org/10.1177/1049909117711997

Segal, J. (2005). *Health and the rhetoric of medicine*. SIU Press.

Shear, M. K. (2015). Clinical practice: Complicated grief. *New England Journal of Medicine*, *372*(2), 153–160. https://doi.org/10.1056/NEJMCP1315618/SUPPL_FILE/NEJMCP1315618_DISCLOSURES.PDF

Shen, M. J., & Wellman, J. D. (2019). Evidence of palliative care stigma: The role of negative stereotypes in preventing willingness to use palliative care. *Palliative & Supportive Care*, *17*(4), 374–380. https://doi.org/10.1017/S1478951518000834

Sleeman, K. E., de Brito, M., Etkind, S., Nkhoma, K., Guo, P., Higginson, I. J., Gomes, B., & Harding, R. (2019). The escalating global burden of serious health-related suffering: Projections to 2060 by world regions, age groups, and health conditions. *Lancet Global Health*, *7*(7), e883–e892. https://doi.org/10.1016/S2214-109X(19)30172-X

Teston, C. (2017). *Bodies in flux: Scientific methods for negotiating medical uncertainty*. University of Chicago Press.

Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*, *19*(6), 349–357. https://doi.org/10.1093/INTQHC/MZM042

Tracy, S. J. (2024). *Qualitative research methods: Collecting evidence, crafting analysis, communicating impact*. John Wiley & Sons.

UAE Ministry of Foreign Affairs - MOFA. (n.d.). https://www.mofa.gov.ae/EN

WHO Eastern Mediterranean region noncommunicable diseases. (2024). https://www.emro.who.int/noncommunicable-diseases/highlights/cancer-control.html

Wise, J. (2012). Dying remains a taboo subject for patients and GPs, finds survey. *BMJ (Clinical Research (Ed))*, *344*(may14), e3356. https://doi.org/10.1136/BMJ.E3356