Palliative and Supportive Care (2015), **13**, 1131–1132.

doi:10.1017/S1478951514001084

ESSAY/PERSONAL REFLECTIONS

The curious case of Dr. A

BEVERLEY JEAN SMITH, M.D.
The Salvation Army Toronto Grace Health Centre, and Division of Palliative Care, Department of Family and Community Medicine, University of Toronto, Toronto, Canada

Dr. A is a physician who practices euthanasia in The Netherlands. His candid revelations about what he liked, or rather did not like to see during the procedure is revealed from a quote from the *Cambridge Quarterly of Medical Ethics*:

> He said, "It is important for you to make your own limits clear to the patient." Dr. A then gave a personal example of one kind of behavioral problem that he would resist: "I do not like it when the patient makes a party out of it," he said. "Some patients want to organize a party around their bed. I do not want to do euthanasia in an atmosphere like that." (Clark & Kimsma, 2004)

This appears curious for a number of reasons. First, the physician was performing what is, for the patient, arguably the most autonomously directed act available from her doctor's toolbox in countries where euthanasia is legalized. Dr. A clearly would need to confirm in some way that a patient wanted or would have wanted her life ended in this manner, by euthanasia, in order to legally perform it in most jurisdictions, and then conform to his patient's wishes. Yet, at the same time he dislikes the patient creating the atmosphere of choice around her deathbed and wants to make his limits clear. It is even referred to as a behavioral problem. The doctor does not want to do it *in this way*. He would resist. What is this about? Where does this aversion to the autonomous choice of patients to party or not to party come from? If loved ones choose to move traditionally funereal rites to the bedrooms of those requesting life-ending medication while putting a celebratory twist on things, a practice no longer idiosyncratic (van Brussel, 2014), why should the medical profession have any opinion on this whatsoever?

Address correspondence and reprint requests to: Beverley Jean Smith, The Salvation Army Toronto Grace Health Centre, 47 Austin Terrace, Toronto, Ontario M5R 1Y8, Canada.
E-mail: bsmith@torontograce.org

A clue may reside in a secondary quote about Dr. A that suggests its origin in mutual respect: "Dr. A spoke of the mutual respect required in the process" (Youngner & Kimsma, 2012).

The practitioner of euthanasia may find it curious in itself that a patient should want to die surrounded by a party. The culture or society from which he derives may reflect this. Each may wonder if proper respect for life and death is demonstrated while partying. If so, then some might feel he has a right to direct the terms under which he will perform the procedure.

Perhaps it comes from the physician's own internal struggles. He knows the seriousness of his act and feels that its solemnity must be mirrored in the eyes of the other in order to assure him that the true gravity of the act is appreciated. The busy medical practitioner himself may not always recognize that the self, even the health professional's self in the action of his duties, is not a unitary concept but may encompass potentially contradictory states, intentions, or desires (Morley, 2010), encompassing discrepancies that may have emotional sequelae. Performing euthanasia itself has contradictory emotional sequelae for physicians in The Netherlands. There are more negative emotions following euthanasia by request than the performance of the same act on a patient who has not requested it (life ending without an explicit request), another curious finding worthy of reflection (Kimsma, 2010).

Perhaps Dr. A's resistance stems from grief. This is a patient the doctor has known as a fellow human being. He is ending that relationship with the ending of the patient's life. He grieves the loss of life or relationship. His grief ought to be reflected in the corresponding grief of the patient and loved ones. If evidence of the grief is missing, then he may suspect either that the act is not being appreciated for what it is, or that the grief is insufficient for the act.

Perhaps it comes from fear of the act being relegated to a technical duty, with the doctor as technician carrying out the process alongside other technicians

called upon to create the party atmosphere, such as the caterer, minister, and musicians. Or perhaps it comes from the seriousness of the office. If one is entrusted with ending another's life, this is an office of the highest fiduciary trust. Partying could undermine this. If others do not support the doctor's internal mindset, they may cheapen what to him may be considered a sacred and solemn act by their contributions to the partying.

Perhaps there is an element of control here. To have control over another's life is a heady thing. Control theory in dying explores the elements of a physician's control and a patient's control in a physician–patient relationship (Redding, 2000). Although patient control over the dying process is a major factor in quality end-of-life care (Singer et al, 1999), up to two thirds of hospice professionals have difficulty relinquishing control (Rinaldi & Kearl, 1990). Questions have been raised about whether the judicial practices around euthanasia increase patient or physician autonomy (Welie, 1992). The dilemma between a personal desire for control on the part of the health professional and palliative principles suggesting the importance of patient control (Lee et al., 2009) is close to the heart of the euthanasia debate, although the concept of the duty to die may challenge this (Hardwig, 2012; van Brussel, 2014). The assertion of control over the home environment, a setting not normally considered part of the health professional's purview, may reflect a subconscious wish to take back the control that the patient has exerted through the physician over the circumstances of her own life and death.

Perhaps it is as simple or as practical as a need to concentrate when administering life-ending amounts of medications, a need for quiet in order to perform his duties correctly. Or maybe it is as personal, as emotional as a past history of a dreadful event at a party gone wild that leads him to an aversion of all parties, not just euthanasia parties. The possibilities are endless.

All is conjecture without speaking to Dr. A. Only he can divine what his dislike of parties in the context of euthanasia signifies. Paltry explorations of possible explanations may contain social judgments vulnerable to error. Colleagues risk falling prey to illusory causal attributions where none exist without definitive qualitative research. However, one thing is certain: attitudes and beliefs influence behavior. And this appears to be a curious behavior. Parties themselves at one's death may also be considered curious by some, a behavioral issue. But Dr. A's dislike of them may be as well. Rational or irrational, Dr. A's view stands as an anecdote, inviting further research on the social, emotional, and psychological factors that come into play with physicians' involvement in euthanasia.

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https://doi.org/10.1017/S1478951514001084 Published online by Cambridge University Press