

Attitudes toward palliative care, conceptions of euthanasia and opinions about its legalization among French physicians

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Abstract

We assume that actors of the professionalization process of palliative care make a special effort to demarcate it from euthanasia, and that such an effort has a significant impact on beliefs and attitudes toward euthanasia among the whole medical profession. We investigated concurrently attitudes toward palliative care, conceptions of euthanasia and opinion toward its legalization among a sample of 883 French general practitioners, oncologists and neurologists. We found four contrasted profiles of attitudes toward palliative care, which were closely correlated with being in touch with palliative care providers. Attitudes toward palliative care were closely correlated with beliefs about which medical practices should be labelled euthanasia, and these beliefs were in turn strongly associated with opinions toward euthanasia legalization. Our results suggest that the relationship between palliative care and euthanasia mixes semantic and strategic aspects, beyond cognitive and conative ones.

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Introduction

The doctor–patient relationship in developed countries has been marked in recent decades by a shift in physicians' attitudes and practices toward promoting patients' greater autonomy, control and participation in the medical decision-making process (Ong, de Haes, Hoos, & Lammes, 1995). Seale (2000) has argued that this shift is closely connected with a broader tendency of late modern societies labelled by Giddens (1991) as the

'risk culture'. In such societies, traditional notions of fate fade away, individuals are exhorted to manage their own 'reflexive project' by developing a calculative attitude to the open possibilities of action, thanks to expert systems that supply them with standardized knowledge and means. According to Seale, the will to control one's life has extended to dying, especially in developed Anglophone countries. In these countries, people seem more prone to express a preference for open awareness of dying to the extent that they want to control the time and manner of their death (Seale, Addington-Hall, & McCarthy, 1997), and palliative care practitioners provide a relevant expertise to assist this will.

Palliative care has its origin in the modern hospice movement, initiated 30 years ago in the UK to promote a new approach to the care of people dying from cancer.

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This movement was fuelled by widespread concerns about patients' rights in the face of medical power and dissatisfaction toward 'overmedicalization' and excessive emphasis on curative efforts in care for the dying (Seale, 2000). Palliative care is dedicated to relieve symptoms of terminal illnesses but also to promote a 'holistic' model of care, focusing on the quality of life and integrating the physical, psychological, spiritual and social aspects of care of patients with life-threatening diseases (Saunders, 1996; Seale, 1998). Since the 1980s, this model has spread across western countries, and palliative care has been more and more integrated into the health care system, in a process of professionalization and specialization. Moreover, the desire to manage one's life and death may imply preferring death to dependency, thus within 'risk societies' the wish for euthanasia may not be considered as an act of surrender due to unbearable suffering, but rather as a key indicator of the preference for autonomy and control (Seale & Addington-Hall, 1994, 1995). So according to some authors the contemporaneous development of palliative care and support for euthanasia may both reflect the same cultural forces that tend to offer opportunities for the patient's autonomy near death (Seale et al., 1997).

Euthanasia and the building of a new medical speciality

Such cultural similarity, contrasts with the results of several empirical studies carried out in developed countries that have emphasized the opposition introduced by the majority of health professionals between palliative care and euthanasia; improvements in palliative care is supposed to prevent patients from requesting euthanasia (Meier, Morrison, & Cassel, 1997; Emanuel & Emanuel, 1998) but also to reduce physicians' support for it (Grassi, Magnani, & Ercolani, 1999; Bonn, 2000). Moreover, in some countries as the Netherlands, developing palliative care facilities is explicitly considered as a way to prevent euthanasia (Gordijn & Janssens, 2000).

Through an analysis of euthanasia, as it is discussed in the professional journals of palliative care, Hermesen and ten Have (2002) show that this issue has been quite controversial within the palliative care community, with a semantic battle with regard to which practices should (or should not) be labelled as euthanasia. Nevertheless, the majority of the examined articles claim that there is no place for euthanasia in palliative care, and the authors argue that the dominant discourse, at least in the medical literature, has been an attempt to articulate palliative care as an alternative to euthanasia. Hermesen and ten Have conclude that further analysis is necessary to clarify the status of euthanasia in the evolution of palliative care, and they make the assumption that discussions about euthanasia may help demarcate the

boundaries of the relatively new discipline of palliative care.

In general, such a demarcation is a crucial element in a strategy of 'professionalization', which is the key-word in occupational sociology to designate both the efforts made to improve an occupation's status and their results.¹ More specifically, the semantic battle around the demarcation from euthanasia may be a strategic issue for the professionalization of palliative care, especially since this process encounters fierce resistance from other medical specialities. Indeed, in the English context, previous studies have emphasized such resistance and the necessity for palliative care to negotiate the boundary between its own field of expertise and other specialities' (Field & Addington-Hall, 1999; Hibbert et al., 2003). Such resistance is a good illustration of the relevance of classic works in occupational sociology and sociology of medicine: professions are made up of segments continuously competing for legitimacy, status and resources (Bucher & Strauss, 1961), and within the medical world there is a prestige hierarchy among specialities, which have distinct vested interests, goals and even conceptions of medical practice (Strong, 1979).

Palliative care and euthanasia in France

The present article aims to translate and test Hermesen and ten Have's assumption in the French context. Indeed, in this country, the euthanasia debate has started later than in Anglophone countries and has overlapped with concerns about the insufficient development of palliative care at the end of 1990s. Therefore, the French context provides a good opportunity to study jointly health care professionals' attitudes toward both issues, and more precisely, to consider euthanasia as a semantic and strategic issue for the professionalization of palliative care. Moreover, considering the medical world as a juxtaposition of competing segments may prove especially relevant for the study of the French medical profession in which the proportion of medical specialists (circa 50%) compared to general practitioners is quite high in comparison to other European countries (Herzlich, Bungener, Paicheler, & Zuber, 1993).

In France, palliative care has developed quite slowly.² As in the United Kingdom, it has encountered resistance

¹Among other characteristics, an occupation becomes a profession if its members get legal monopoly over an area of expertise and activity, if they control the organisation and content of training for future members, and if they obtain the exclusive right to evaluate the way their tasks are performed (Freidson, 1986, 1988; Abbot, 1988).

²In France, the first specialized unit for palliative care opened in 1987, and 10 years later only 50 out of 3500 hospitals had such a unit.

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