RNIOS: Injecting humor into health challenges

"In case you are wondering, we named it Sidney," my patient offered during a recent visit.

"Pardon?" I responded.

"I was cleared by the transplant team and Sidney the kidney is going to my sister."

I believe the Random Naming of Inanimate Object Syndrome (RNIOS, pronounced *rhinos*) has been well described in many esteemed journals (or at least in this one starting now). I was reminded of this syndrome by my favorite youngest niece, who has faced more than her fair share of health challenges at a young age.

It started with her nasogastric tube, which was named Babar after the famous elephant for obvious reasons. After Babar left on permanent safari, her new J-tube became Lil' J. When hooked up to the portable pump and backpack for exploring purposes, Dora was born. Apparently when Lil' J and Dora's collaborative efforts fail they are covered by the blanket moniker, PITA, for pain in the ass. Sadly, extra help was needed, so Juliet the central line punctured the picture. Groshong and Hickman are such ugly names, but since her catheter is a Bard product Shakespeare was happy to lend a name by which any catheter would smell as sweet. Lastly, my niece was pretty excited to find out that her wheelchair for long-distance travel is a Helio product. This way she can sit in Julio down by the school yard, hey, hey.

Apparently, she is not the only one afflicted by this syndrome. She has heard of many port-a-caths with names such as Persephone and Penelope. She is aware of one girl who named her feeding tube Sally, and her pump Harry, as a result of *When Harry Met Sally*. Another acquaintance loves *Grey's Anatomy*, so her venting G-tube immediately became McDrainy.

This random naming practice inserts some humor into often trying and difficult situations. I am constantly impressed by my niece's ability to accept her situation with grace and levity even when faced with one difficult challenge after another. She chooses to soldier on and surmount the obstacles put in her way, all the while sharing her experiences with others in a compassionate and caring way. Her blog (http://findingmymiracle.com) puts my editorial efforts to shame. Her honest, well-crafted thoughts offer important reflection for those of us on the other side of the stethoscope. I have often encouraged her to submit an article to the *BCMJ,* but to this point she has resisted. I'm sure this will no longer be possible because the half dozen or so readers of my editorials (depending on if you count my family members) will now be clamoring for her authorship.

—DRR

Death: Natural or hastened

Growing up I remember my parents referring to the announcements section of their local newspaper as the Hatch, Match, and Dispatch. During my professional career thus far, I have thankfully seen more patients hatched than dispatched. When patients of mine have passed away, I have usually felt a sense of sadness. Or so I thought. Perhaps it was better described as empathy. Or so I thought.

Until the first day of March this year, I believed that I understood what the grieving relatives were going through. That was the day my father passed away. He was a wonderful dad, but this is not the forum in which to eulogize him. Suffice it to say that I now have a deeper appreciation for the grief that some of my patients and their relatives have been through.

Although I would rather talk about my dad's life (which was full, productive, and happy), the theme of this editorial is death. My dad's death was as comfortable, peaceful, and dignified as he had hoped for. He fell asleep on his last night, in my parents' bedroom, holding my mother's hand. He didn't wake up the next morning. At the time of writing this, 6 months have gone by, and I still feel sad, thinking about our loss.

Another thing I learned along the way was how family members of a person nearing the end of life may try to influence end-of-life discussions and advance-directive discussions. Thankfully, in our family we are all very close, and despite some minor philosophical differences, we were all able to allow our dad to make the choices he wanted, and not necessarily coerce him to make choices that some of us had hoped for.

What I am not comfortable with is hastening a patient's death.

As part of our family practice, my partners and I provide palliative care to our dying patients. Although we have a palliative care physician in our community, I prefer to continue as most responsible physician to my palliative patients. Our palliative physician colleague is happy to act as a resource for us when called upon to do so. I am happy to continue to provide comfort, care, and dignity at the end of a patient's life and to allow for the natural process of death to take place. What I am not comfortable with is hastening a patient's death. Although I don't agree with a person wanting to end their life, I accept the concept that people should have freedom of choice, including the right to control their own body and their own life, and that lawmakers should not make laws that prevent people being able to choose when and how they die.

Using that same argument, we as physicians should also have the right to refuse to assist a person in hastening their death. Whether we do so based on religious or ethical grounds is not important. Some of us may fear the so-called slippery slope that legalizing euthanasia could start us on. Some physicians may simply believe that if we cannot ease a person's suffering then we have failed as physicians.

I shudder at the news emanating from Quebec, which suggests that doctors are being coerced to provide assistance to patients who wish to end their lives. If lawmakers in the rest of Canada choose to support physician-assisted euthanasia, I trust they will afford the right of choice to both the patient and the physician.

—DBC