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Should assisted suicide be performed by physicians only? Results of a survey among physicians in six European countries and Australia

_Original article

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Abstract_French and German abstracts see p. 8

Background: Whereas there is broad agreement that euthanasia should be performed by physicians only, this is contested for (physician-) assisted suicide.

Methods: We conducted a survey to investigate whether European and Australian physicians see morally relevant differences between assisted suicide and euthanasia, and whether, after a possible legalization of assisted suicide, they believe it should be performed by physicians only.

Results: 10 139 questionnaires were studied. 76% of the physicians in Belgium, 66% in the Netherlands, 62% in Australia, 48% in Denmark, 44% in Switzerland, and 10% in Sweden thought that assisted suicide should be performed by physicians only. 16% of the physicians in Italy, 30% in Australia, 32% in the Netherlands, 37% in Belgium, 40% in Denmark, 47% in Switzerland, and 51% in Sweden regarded assisted suicide to be morally different from euthanasia. Multinomial logistic regression analysis confirmed the predominant role of the factor country for these opinions.

Conclusions: Country-specific views on the question of whether assisted suicide, after a possible legalization, should be performed by physicians only, are highly diverse, even within Western European countries. These differences should be taken into account when searching for common grounds for regulating assisted dying in westernized countries or even within Europe.

Key words: assisted suicide; euthanasia; assisted dying; end of life; professional role

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Introduction and aim of the study

In the Netherlands and Belgium it is taken for granted and legally fixed that assisted dying (usually performed as euthanasia) is performed by physicians only. However, in many other countries such as the US (1), Germany (2), Australia (3), and Switzerland (4–5), the extent of physicians' involvement in the practice of assisted suicide is the subject of a heated debate within the medical, political, and religious community (6–7).
Whereas there is a significant body of literature on opinions of the general public (8–9) as well as of physicians (10–12) on assisted dying, opinions on the question of the appropriate role of physicians within this field are scarce.
Furthermore, a look at existing models of assisted dying shows that the question of the appropriate role of the physician is related to the different features of assisted suicide on the one hand and euthanasia on the other hand. Those countries or states that allow assisted suicide only (Switzerland, the US states of Oregon and Washington) at the same time allow a more extended role of non-physicians than those countries that allow both assisted suicide and euthanasia in a common framework (The Netherlands and Belgium) (6). This makes sense as in assisted suicide, once the lethal medication is issued by a physician, a patient is free as to where, when and accompanied by whom he or she is going to end his/her life. This enables or even makes necessary a role for right-to-die societies such as Compassion and Choices in Oregon and Washington, or Exit and Dignitas in Switzerland. EURELD is probably the largest empirical research project in medical end-of-life decisions carried out in Europe so far (13–14). Whereas part one focused on practices, part two mainly investigated physicians' attitudes in this field. In part two, Australia was also included (15–18). This paper analyses and presents data from part two of the EURELD study, focusing on the question of whether physicians see assisted suicide as morally different from euthanasia, and whether, after a possible legalization of assisted suicide, they believe it should be performed by physicians only. Given the above-mentioned background of existing models of assisted dying, our hypothesis was that those physicians who thought that there is a moral difference between assisted suicide and euthanasia would be more likely to reject the proposition that assisted suicide should be performed by physicians only.

Methods

A written questionnaire with structured questions was sent to practising physicians in Australia, Belgium (Flanders), Denmark, Italy (Regions of Emilia-Romagna, Trento, Tuscany and Veneto), the Netherlands, Sweden, and Switzerland at the end of 2002.
In each country physicians from specialties frequently attending dying patients were asked to participate: anaesthesiology, general practice, geriatrics, gynaecology, internal medicine, neurology, nursing home medicine (only in the Netherlands), oncology, pulmonology and surgery. For each specialty a random sample of up to 300 physicians was drawn from the professional registers. This method of sampling resulted in between 1870 (Denmark where several specialties consisted of less than 300 physicians) and 3873 (Italy where general practitioners were oversampled) questionnaires per country being sent out. In order to guarantee anonymity, the questionnaires were not numbered, and the respondents were asked to send back an answering card, separately from the questionnaire, to indicate that they had responded separately from the questionnaire. A detailed description of the method used can be found in previous publications on EURELD study two (15–18).
An English version of the eight-page questionnaire was translated into the relevant languages and back into English to search for inconsistencies. When referring to medical decisions, a precise description was given rather than using terms that would be open to interpretation. In the analysis, assisted suicide was defined as the prescription or supplying, euthanasia as the administration of drugs with the explicit intention of hastening the end of the patient's life on the patient's explicit request. The term assisted dying was used to include both euthanasia and assisted suicide. Beside questions on the physicians' personal characteristics, attitudes and opinions concerning end-of-life care were assessed by studying the responses to a list of different statements on ethical issues in end-of-life care.
The data of all countries were combined in a common database to ensure identical coding and analysis procedures. When presenting frequencies and fitting regression models, weighting factors were used to correct for the different sampling fractions and response percentages in the different strata (represented by country and specialty), making them representative for all physicians in the sampled specialties. Further weighting for non-response adjustment was not necessary as there were no significantly different response rates in other subgroups of physicians (19).

This study focuses on the following statements

(1) «If assisting in suicide is or were to become legal, it should be performed by physicians only». However, this statement was omitted in the Italian version of the questionnaire as in the Italian context the question was seen as not appropriate and possibly impairing the response rate in this country.
(2) «There is a moral difference between prescribing or supplying drugs in lethal doses, and administering drugs in lethal doses».

Weighted percentage of agreement {(strongly) agree/undecided/(strongly) disagree}) with statements and 95% confidence intervals are reported. For each statement a multinomial logistic regression has been performed to test the relationship between country and the statement as well as the relationship between the two statements, controlling for physicians characteristics (sex, age, importance of religion/philosophy of life for end-of-life decisions, number of treated terminally ill patients, experiences in euthanasia or assisted suicide). Survey' STATA 8 commands were used to take strata and weighting into consideration (20). In logistic regression analysis, independent variables are not allowed to correlate highly with one another. As a high correlation existed between specialty and number of terminally ill patients treated, the variable «specialty» had to be excluded from the analysis.

Results

10 139 questionnaires were studied. The response rates were 53% in Australia, 58% in Belgium, 68% in Denmark, 39% in Italy, 61% in the Netherlands, 60% in Sweden, and 64% in Switzerland. The majority of physicians in all countries were male and older than 40 years. Depending on the country, 62% – 80% of the investigated physicians were male, 72% – 95% were > 40 years, and 40% – 66% were general practitioners (10).

That assisted suicide should be performed by physicians only, was the opinion of 76% of physicians in Belgium, 66% in the Netherlands, 62% in Australia, 48% in Denmark, 44% in Switzerland, and 10% in Sweden. In total, 52% of the physicians investigated agreed or strongly agreed with an exclusive role for physicians in assisted suicide (table 1).

That there is a moral difference between assisted suicide and euthanasia was the opinion of 16% of physicians in Italy, 30% in Australia, 32% in the Netherlands, 37% in Belgium, 40% in Denmark, 47% in Switzerland, and 51% in Sweden. In total, 37% of the physicians investigated thought assisted suicide to be morally different from euthanasia (table 2).

In comparison with Dutch physicians, physicians from Belgium (OR 2.54, CI 1.63 – 3.69), were more likely to agree with the statement «If assisting in suicide is or were to become legal, it should be performed by physicians only». Physicians from Switzerland (OR 0.45, CI 0.31 – 0.64), but in particular from Sweden (OR 0.07, CI 0.04 – 0.10) gave less support than their Dutch counterparts (table 3).

For the statement «Do you think that there is a moral difference between prescribing or supplying drugs in lethal doses, and administering drugs in lethal doses?», physicians: from Sweden (OR 2.32, CI 1.69 – 3.18), and Switzerland (CI 1.89, CI 1.42 – 2.50) were more likely to agree than physicians from the Netherlands. Physicians from Italy were less supportive (OR 0.37, CI 0.28 – 0.49) (table 4).

Discussion

This paper provides empirical data on European and Australian physicians' opinions on whether, after a possible legalization of assisted suicide, it should be performed by physicians only, and on whether assisted suicide is morally different from euthanasia.

With regard to the question of whether assisted suicide should be performed by physicians only, we found striking differences among the countries studied. The fact that 76% of all physicians in Belgium, but only 10% of all physicians in Sweden gave an affirmative answer to this question brings us to the conclusion that the appropriate role of the physicians in assisted dying might be one of the most contested questions in this field. Also, the ambivalence of many physicians in this field contrasts with the fact that discussions in the media, courts, and legislatures often take it for granted that assistance in dying is exclusively a physician's task (21). In order to avoid being overtaken by possible or actual political developments, physicians are challenged to work out the role they could conceivably play in assisted dying (7). Particularly striking was the strong rejection of assisted suicide as an exclusive task for physicians by Swedish physicians. The reason for this strong rejection is not fully clear. A recent survey among Swedish physicians showed that 34% were pro physician-assisted suicide, 39% against it and 25% were doubtful. Psychiatrists, as well as older physicians (>50 years) were significantly more accepting than oncologists and younger physicians (22). But unlike the study presented in this paper, the hypothetical question used by Lindblad et al. implied a number of safeguards in assisted suicide: The patient is at the end of life and his/her suffering is unbearable; the patient must be decision-competent and well informed about alternative palliative measures; the patient must be asking for PAS of his/her own accord, without being influenced by others; the patient must be capable of administering the drug by him/herself; the patient must not be suffering from any treatable psychiatric disorder; the treating physician must have known the patient for a considerable length of time; a second physician must verify that the listed criteria are fulfilled; the measure has been legally accepted by the authorities.

It is interesting to learn how many physicians still continue to view assisted suicide as morally different from euthanasia. This might be expected from a country such as Switzerland where assisted suicide but not euthanasia is legal and openly practiced. But the result of even one third of Dutch physicians perceiving such a moral difference is striking and surprising, as issues of ending of life are highly medicalised in the Netherlands (23) and euthanasia and assisted suicide are treated as two of a kind in the Dutch law on ending of life on request. Moreover, the frequency of assisted suicide appeared to be diminished more strongly than that of euthanasia in 2005 (24). This can be seen as an indication that legal regulation of assisted dying does not necessarily meet the ethical questions faced by doctors in clinical practice. The clear rejection of such a difference by Italian physicians might be due to the fact that most physicians in this country see any type of assisted dying as morally unacceptable (10).

Multinomial logistic regression analysis revealed significant differences between countries as predictor for both statements studied, confirming again the well-known fact that country is the most important predictor of physicians' attitudes in medical end-of-life decisions (25). Beyond that however, regression analysis could not support our hypothesis that those physicians who thought that there is a moral difference between assisted suicide and euthanasia would be more likely to reject the proposition that assisted suicide should be performed by physicians only. Apparently, the idea that there is a moral difference between assisted suicide and euthanasia is not intrinsically linked to beliefs about proper (medical) role. Physicians could believe that there is a difference between the two, yet some of them could still hold the view that it is the physician's task to engage in both of them, or, the opposite position, that neither of them are physicians' tasks. Finally, for those who regarded assisted suicide as morally different from euthanasia we don't know in what way they did so. Some may believe that assisted suicide is more acceptable than euthanasia because of the patient's choice being confirmed or because it might be seen as less burdening for the participating doctors (26–27). But others may believe that assisted suicide is morally more

problematic as a result of a connotation with ordinary suicide, or because they might imply stricter medical safeguards for euthanasia as compared to assisted suicide (note that the Belgian law on euthanasia did not clarify the legal status of assisted suicide) (7). Further research on all these open questions is needed in order to find out in what exactly consists the moral difference that lies behind the diversity of views as described in this paper.

We conclude that country-specific views on the question of whether assisted suicide, after a possible legalization, should be performed by physicians only, are highly diverse, even within Western European countries. These differences should be taken into account when searching for common grounds for regulating assisted dying in westernized countries or even within Europe.

Table 1. Weighted percentages (95% CI) of agreement with the statement «If assisting in suicide is or were to become legal, it should be performed by physicians only» (row percentages)[1]

Country	(strongly) agree	undecided	(strongly) disagree
Australia	61.9 (57.8 – 66.0)	19.7 (16.6 – 23.3)	18.3 (15.3 – 21.9)
Belgium	76.3 (72.6 – 79.7)	14.3 (11.6 – 17.5)	9.3 (7.2 – 12.0)
Denmark	48.2 (43.5 – 52.9)	24.3 (20.6 – 28.6)	27.5 (23.5 – 31.9)
Netherlands	66.0 (61.7 – 70.1)	20.2 (16.9 – 24.1)	13.7 (11.0 – 17.1)
Sweden	9.7 (7.6 – 12.3)	23.7 (20.7 – 27.0)	66.5 (62.9 – 70.0)
Switzerland	43.5 (40.2 – 46.8)	21.6 (19.0 – 24.5)	34.9 (31.8 – 38.1)
Total	51.9 (50.2 – 53.7)	20.3 (18.9 – 21.7)	27.8 (26.3 – 29.3)

1 Statement not asked in Italy

Table 2. Weighted percentages (95% CI) of agreement with the statement «Do you think that there is a moral difference between prescribing or supplying drugs in lethal doses, and administering drugs in lethal doses?» (row percentages)

Country	(strongly) agree	undecided	(strongly) disagree
Australia	29.9 (26.2 – 33.8)	9.3 (7.1 – 12.0)	60.8 (56.7 – 64.9)
Belgium	36.7 (32.7 – 40.9)	6.9 (5.1 – 9.3)	56.4 (52.2 – 60.5)
Denmark	40.2 (35.7 – 44.9)	6.5 (4.6 – 9.2)	53.2 (48.6 – 57.9)
Italy	15.7 (13.9 – 17.7)	3.7 (2.9 – 4.9)	80.5 (78.4 – 82.5)
Netherlands	32.3 (28.3 – 36.6)	10.8 (8.3 – 14.0)	56.8 (52.4 – 61.2)
Sweden	50.5 (46.8 – 54.1)	10.5 (8.3 – 13.1)	39.1 (35.6 – 42.6)
Switzerland	46.7 (43.4 – 50.1)	7.6 (6.0 – 9.5)	45.7 (42.4 – 49.0)
Total	37.3 (35.7 – 38.9)	8.6 (7.7 – 9.6)	54.1 (52.4 – 55.7)

Table 3. Odds ratios (95% CI) for agreement with statement «If assisting in suicide is or were to become legal, it should be performed by physicians only» (Multivariate logistic regression analysis, significant odds rations given in bold)[1]

Variable	Odds Ratio (95% CI)
Country	
Australia	1.27 (0.86 – 1.87)
Belgium	**2.54** (1.63 – 3.96)
Denmark	0.71 (0.48 – 1.08)
The Netherlands[2]	1.00
Sweden	**0.07** (0.04 – 0.10)
Switzerland	**0.45** (0.31 – 0.64)
There is a moral difference between assisted suicide and euthanasia[3]	
(strongly) agree	1.00
(strongly) disagree	1.04 (0.74 – 1.47)
undecided	0.96 (0.77 – 1.19)

1 This question was not asked in the Italian questionnaire; the category «undecided» is excluded from this analysis. The reference group is (strongly) disagree.
2 The Netherlands = reference group
3 (strongly) agree = reference group

Table 4. Odds ratios (95% CI) for agreement with statement «Do you think that there is a moral difference between (prescribing/supplying drugs in lethal doses), and (administering drugs in lethal doses)?» (Multivariate logistic regression analysis, significant odds rations given in bold)[1]

Variable	Odds Ratio (95% CI)
Country	
Australia	0.88 (0.65 – 1.20)
Belgium	1.13 (0.85 – 1.52)
Denmark	1.26 (0.92 – 1.72)
Italy[2]	**0.37** (0.28 – 0.49)
The Netherlands[3]	1.00
Sweden	**2.32** (1.69 – 3.18)
Switzerland	**1.89** (1.42 – 2.50)
Assisting in suicide should be performed by physicians only[4]	
(strongly) agree	1.00
(strongly) disagree	1.08 (0.87 – 1.35)
undecided	1.08 (0.87 – 1.35)

1 The category «undecided» is excluded from this analysis. The reference group is (strongly) disagree.
2 The Netherlands = reference group
3 For Italy, a separate multinomial logistic regression has been performed without the statement «Assisting in suicide should be performed by physicians only» as independent variable; (strongly) agree = reference group
4 This question was not asked in the Italian questionnaire

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Résumé

L'assistance au suicide ne devrait-elle être pratiquée que par des médecins? Résultats d'un questionnaire auprès de médecins de six pays européens et d'Australie.

Contexte: Alors qu'un large consensus limite la pratique de l'euthanasie aux médecins, ce point est controversé s'agissant de l'assistance (médicale) au suicide.

Méthodes: Nous avons administré un questionnaire pour explorer si les médecins d'Europe et d'Australie voient une différence moralement pertinente entre l'assistance au suicide et l'euthanasie, et si, dans le cas où l'assistance au suicide était légale, ils pensent qu'elle ne devrait être pratiquée que par des médecins.

Résultats: Nous avons analysé 10 139 questionnaires. 76% des médecins en Belgique, 66% en Hollande, 62% en Australie, 48% au Danemark, 44% en Suisse, et 10% en Suède pensait que l'assistance au suicide ne devrait être pratiquée que par des médecins. 16% des médecins en Italie, 30% en Australie, 32% en Hollande, 37% en Belgique, 40% an Danemark, 47% en Suisse et 51% en Suède estimaient l'assistance au suicide moralement différente de l'euthanasie. L'analyse logistique multinomiale confirme la prédominance du pays de pratique comme facteur déterminant de ces opinions.

Conclusions: Les points de vue dans différents pays concernant la pratique de l'assistance au suicide exclusivement par des médecins, si elle était légale, sont très divers même parmi les pays d'Europe occidentale. Il est important de tenir compte de ces différences en cherchant un champ commun en vue de la réglementation de la mort assistée dans les pays occidentaux, même à l'intérieur de l'Europe.

Zusammenfassung

Soll der assistierte Suizid nur von Ärztinnen und Ärzten geleistet werden dürfen? Resultate einer Umfrage bei Ärztinnen und Ärzten in sechs europäischen Ländern und Australien.

Hintergrund: Es herrscht weithin Einigkeit darüber, dass Euthanasie nur von Ärzten und Ärztinnen geleistet werden sollte; für den (ärztlich) assistierten Suizid ist dies nicht der Fall.

Methoden: Untersucht wurde, ob europäische und australische Ärzte und Ärztinnen moralisch relevante Unterschiede zwischen Euthanasie und assistiertem Suizid sehen, und ob sie – nach einer möglichen Legalisierung des assistierten Suizids – glauben, dass dieser nur von Ärzten und Ärztinnen geleistet werden sollte.

Resultate: Untersucht wurden 10 139 Fragebogen. 76% der Ärzte und Ärztinnen in Belgien, 66% in Holland, 62% in Australien, 48% in Dänemark, 44% in der Schweiz und 10% in Schweden waren der Ansicht, dass der assistierte Suizid nur von Ärzten und Ärztinnen ausgeführt werden sollte. 16% der Ärzte und Ärztinnen in Italien, 30% in Australien, 32% in Holland, 37% in Belgien, 40% in Dänemark, 47% in der Schweiz und 51% in Schweden betrachteten den assistierten Suizid und die Euthanasie als moralisch unterschiedlich. Eine multinomiale logistische Regressionsanalyse bestätigte die bestimmende Rolle des Faktors «Land» für diese Meinungen.

Konklusion: Selbst innerhalb westeuropäischer Länder sind die länderspezifischen Ansichten darüber, ob der assistierte Suizid – nach seiner möglichen Legalisierung – nur von Ärzten und Ärztinnen geleistet werden sollte, sehr unterschiedlich. Wenn für die Regulierung des assistierten Suizids in westlich geprägten Ländern oder sogar in ganz Europa nach einer gemeinsamen Basis gesucht wird, dann sollten diese Unterschiede berücksichtigt werden.

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