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Euthanasia or Physician-Assisted Suicide: Attitudes of European Physicians

Abstract

The Hippocratic Oath strictly prohibits the administration of lethal medication and assisting someone in killing him or herself (1). A significant number of people, however, have felt that this strict prohibition is no longer tenable. They are of the opinion that, in some cases, medicine should help a patient to die peacefully, rather than prolong unbearable and pointless suffering. After discussions of euthanasia had been going on in Europe and the U.S. for more than a century, euthanasia was legalized in two countries, Belgium and the Netherlands, in 2002 (2). At present, there also exist legally sanctioned possibilities for assisted suicide in-besides the Netherlands-Switzerland and Oregon (3). All these developments have generated an enormous amount of literature on the subject of euthanasia. Given the huge quantity of recent articles on the attitudes of physicians towards euthanasia, a review seemed relevant. (4)

Key words: **euthanasia, physician-sssisted suicide, ethics, medicine.**

DEFINITIONS OF EUTHANASIA

Due to difficulties related to the definition of euthanasia, some researchers have refrained from using the term and have worked with descriptions while performing their research (9-15), or have tried to discover which medical acts or omissions physicians themselves consider to be euthanasia (16,17). Among those surveys that do opt to use the term "euthanasia", there is no unanimity about which acts or omissions should be called euthanasia. Following Broeckaert's typology, treatment decisions at the end of life can be divided into three categories (18,19), all of which could, in certain cases, represent interpretations of the term euthanasia:

1. forgoing curative or life-sustaining treatment;
2. pain and symptom control;
3. active termination of life.

To the first category belong decisions to withhold or withdraw curative or life-sustaining treatment no longer deemed meaningful or effective. In a minority of the studies, the distinction between this category and active termination of life is upheld by using the contrast active euthanasia versus passive euthanasia. While the former refers to the intentional shortening of life through active means, for example administering a lethal dose of medicine, the latter most often involves withdrawing or withholding treatment. Yet, in the majority of the recent studies, this distinction is not made and the term euthanasia is reserved for actions directly aimed at ending life. To the second category belong treatments within the framework of palliative care, pain control and palliative (terminal) sedation, both of which have been suggested to have, at least in certain cases, a life-shortening effect. Most authors refrain from applying the term euthanasia to this kind of therapy. This is in line with objective findings that point out that adequate use of painkillers does not have a negative effect on patient survival (20). Nevertheless, Bittel *et al.* (21) call symptom control that could unintentionally hasten the patient's death "indirect active euthanasia", as opposed to "direct active euthanasia" ("intentional, rapid, and nonpainful termination of a patient's life"). Use of similar terms is found in the article by Ryynänen *et al.* (22). The French practice of the so-called "cocktail lytique", a combination of medicines-consisting of a neuroleptic, an antihistamine, and an opioid-has more obvious consequences for the survival rate of terminal patients. Peretti-Watel *et al.* (16) examined whether French physicians consider this treatment to be euthanasia.(4). To the third category belong medical acts that unmistakably and intentionally shorten life. Since acts that belong to the two previous categories do not necessarily hasten death, logically, the use of the term euthanasia should be restricted to the third category. Within this third category, three different subcategories can be distinguished. Also here, there is disagreement as to which actions should be called euthanasia. Firstly, following the official Belgian and Dutch definition of euthanasia, many authors have opted to restrict the use of the term to the deliberate and active ending of life by someone else at the patient's explicit request, the first subcategory. The second subcategory, physician-assisted suicide-a physician intentionally assisting a patient to end his or her life-is generally not considered euthanasia. Physician-assisted suicide is called "passive euthanasia" by Maitra *et al.* (23). They use "passive euthanasia" to translate the German "Passive Sterbehilfe". Euthanasia in the Belgian and Dutch interpretation is, for them, "active euthanasia" ("Aktive Sterbehilfe"). The third subcategory, in which a patient's life is ended without the patient's explicit request, is termed euthanasia by a few authors (21,24,25). Yet several researchers implicitly suggest, by their use of the term "active voluntary euthanasia", that they would agree with designating this practice euthanasia (22,26-28). Writing about voluntary euthanasia-euthanasia at a patient's request-implies the existence of nonvoluntary euthanasia-euthanasia without a patient's request.

MEASURING ATTITUDES

It is clear that there exist different opinions about the meaning of the term euthanasia. Following the definitions of Broeckaert, it will adopt the following terminology and categorization (18,19).

VOLUNTARY EUTHANASIA

The intentional administration of lethal drugs in order to painlessly terminate the life of a patient suffering from an incurable condition deemed unbearable by the patient, at this patient's request.

In most countries, the majority of physicians oppose voluntary euthanasia, though there is a huge variety in the results. Ryynanen *et al.* (22) found that, for just 3% to 9% of Finnish physicians, voluntary euthanasia is ethically acceptable. Miccinesi *et al.* (12) calculated that, in Belgium, 78% of physicians find voluntary euthanasia acceptable. Concerning the willingness to practise voluntary euthanasia, 5% of German physicians (23) and 55% of Swiss cancer-centre physicians (29) claim to be willing to perform voluntary euthanasia.

PHYSICIAN-ASSISTED SUICIDE

A physician intentionally assisting a patient to terminate his or her life, at this patient's request.There are important differences concerning the general acceptance of physician-assisted suicide. McGlade *et al.* (26) state that, for 73% of general practitioners in Northern Ireland, physician-assisted suicide is ethically unacceptable; while Maitra *et al.* (23) found physician-assisted suicide to be acceptable for 80% of German general practitioners. Guedj *et al.* (24) studied attitudes toward not intervening when a patient intends to commit suicide. The researchers found that this was the only instance in which physicians tended to consider the hastening of death acceptable. In most countries, a minority of physicians declared themselves willing to assist a patient when he/she intends to commit suicide, but percentages vary from 12% for geriatricians in the U.K. (27) to 42.59% for German physicians (23).

NONVOLUNTARY EUTHANASIA

The intentional administration of lethal drugs in order to painlessly terminate the life of a patient suffering from an incurable condition deemed unbearable, not at this patient's request. Other authors deal with the administration of lethal drugs without the patient's request. Reported acceptance of nonvoluntary euthanasia varies between 18% and 45% (12). Nonvoluntary euthanasia can be practised in the case of competent and incompetent patients. In the case of an incompetent patient, it is possible that the patient has formulated a euthanasia wish in an advance directive. Although in the Netherlands the legal framework allows for advance euthanasia directives, most physicians oppose the application of these directives (30,31).

LEGALIZATION

Many authors discuss the problem of legalization of euthanasia and physician-assisted suicide. Agreement with legalization varies from 23% (27) to 59% (23). In several studies, more physicians favour legalization of physician-assisted suicide than of euthanasia (21,23,26,27,32). In the study by Pasterfield *et al.* (33), the opposite was found.

ARGUMENTS FOR/AGAINST EUTHANASIA AND PHYSICIAN-ASSISTED SUICIDE

In several studies, physicians had the opportunity to indicate which factors influenced them to look favourably or unfavourably on euthanasia, physician-assisted suicide, or their legalization. Arguments in favour include: the right of the patient to decide about his own life and death; the desire to die with dignity (23,25,27); and the conviction that legalization of euthanasia and physician-assisted suicide could help to avoid futile treatment (27). Reasons for a negative attitude toward life-shortening measures are: possible pressure on vulnerable patients (23,25,27); unwillingness to decide about life and death (25); uncertainty about prognosis (23,25); and religious opposition (21). Generally, fear of prosecution is not considered a major obstacle to participating in euthanasia and physicianassisted suicide. Several physicians mention the availability of good palliative care as an explanation for their negative attitudes toward euthanasia and physician-assisted suicide. Thus, many physicians seem to argue that most patients will stop requesting euthanasia as soon as they experience the benefits of good palliative care (5,12,23,25,27,28,32).

CONTEXTUAL FACTORS

Differences in the attitudes of physicians may be explained by several internal factors (age, gender, religion, and speciality of the physician) and external factors (place of residence and patient characteristics).

AGE

More frequent practice of euthanasia by younger physicians (12,34) suggests that their attitude toward this practice is more lenient. A study in Finland (22) showed that termination of life by a physician is more acceptable to younger physicians. However, Rurup *et al.* (35) found that older physicians are more inclined to approve of availability of lethal medicine for very old people wishing to end their lives. Maitra *et al.* (23) concluded from their research that attitudes toward physician-assisted suicide and voluntary euthanasia are not influenced by age.

SPECIALITY

Physicians are less often in favour of actively shortening the dying process than are the general public and nurses (24,30,36,37). Physicians practising specialities such as oncology, geriatrics, and palliative care, in which they are frequently confronted by prolonged terminal suffering, have more negative attitudes toward active termination of life (12,29,30,38). Dickinson et al. (28) found that the attitudes of intensive care physicians toward euthanasia are often more positive than the attitudes of geriatricians. Still, at least one study found no significant relationship between physicians' speciality and their attitude toward euthanasia and physician-assisted suicide (23).

GENDER

In most articles gender does not appear to be a major factor that influences the attitudes of physicians. Only a few articles (12,22,39,40) mention a significant difference between the attitudes of male and female physicians. According to these articles, female physicians find active ending of life less acceptable than their male colleagues.

RELIGION

At least 13 articles explicitly discuss the possible influence of religiosity. As could be expected, several authors find that religious persons are less in favour of euthanasia and physician-assisted suicide. Yet, not all articles that study this factor confirm its significance (23,32).

COUNTRY

In a study that compared the attitudes and practices of physicians in six European countries, Miccinesi et al. (12) concluded that attitudes are most influenced by the country in which the physician resides. The research groups of the large-scale comparative studies by Sprung *et al.* (13) and of the EURELD-consortium (10,12,41) examined end-of-life attitudes and practices in several European countries. The remaining articles deal with northwestern Europe: Belgium, Finland, France, Germany, the Netherlands, Northern Ireland, Sweden, Switzerland, and the U.K. The article by Parpa *et al.* (15) is the only article exclusively dealing with a south European country (Greece). The article by Sprung *et al.* (13) does not contain geographical comparisons concerning euthanasia and physician-assisted suicide. Miccinesi *et al.* (12) contend that, contrary to expectations, there is no north-south contrast concerning physicians' attitudes. In this study, Swedish and Italian physicians are least in favour of using lethal medicine. Physicians in Belgium and the Netherlands, the two countries that have euthanasia laws at present, are most open toward the use of lethal drugs.

PATIENT CHARACTERISTICS

The researchers of the EURELD-consortium examined which patient characteristics would have a positive influence on a physician's willingness to hasten death in hypothetical scenarios. They found that a request by the patient is the most frequently mentioned decisive element (10). According to other articles, unbearable suffering would enhance the chance that a request by the patient to hasten his or her death is granted (42,43). Lack of perceived unbearable suffering, absence of severe disease, possibility of alternative treatments, and depression or incompetence of the patient decrease the willingness of a physician to fulfil a request for euthanasia or physician-assisted suicide (30,42-44).

DISCUSSION

In the American review we observed huge differences between different surveys regarding the ethical acceptability of voluntary euthanasia and physician-assisted suicide, their legalization, and willingness to participate in these medical actions.

There seem to be more physicians who say they would be willing to perform voluntary euthanasia than physicians who have actually been involved in a voluntary euthanasia case (23). There are three notable explanations for this finding. First, some physicians who say they would perform voluntary euthanasia may eventually prefer not to administer death-hastening medicine, or they may postpone the act until a natural death occurs. Euthanasia involves the killing of another human being and this is certainly not an easy thing to do. second, the number of persistent requests for euthanasia from patients are comparatively few (46) and, hence, few physicians may actually be confronted with a persistent request for euthanasia. Third, in most countries, performing voluntary euthanasia is illegal. Under such circumstances, performing voluntary euthanasia is not evident at all. Concerning the legalization of end-of-life practices, it might be expected that physicians would be more in favour of a legalization of physician-assisted suicide than of voluntary euthanasia, although in general physicians do not support either. In the case of physician-assisted suicide, the patient him or herself eventually performs the life-shortening act; in the case of voluntary euthanasia, the physician is more directly responsible. This expectation is confirmed in several studies in which more physicians favour legalization of physician-assisted suicide than of voluntary euthanasia (21,23,26,27,32). Also in the American review by Dickinson *et al.,* it was observed that physicians are more favourable to physician-assisted suicide (6). From this perspective, it is remarkable that the Belgian parliament has opted to legalize voluntary euthanasia and not physician-assisted suicide (47).

Good palliative care is often seen as a type of care that makes voluntary euthanasia, physician-assisted suicide, and their legalization superfluous. This argument is frequently raised when the Dutch euthanasia policy is discussed. The Dutch legalization of physician-assisted suicide and voluntary euthanasia was said to have been prompted by the absence of adequate palliative care in the Netherlands (47). Dutch palliative care has developed significantly since the time, more than two decades ago, when the Dutch euthanasia practice was established (48). Yet, in 2001, the number of Dutch physicians who thought palliative care renders euthanasia and physician-assisted suicide redundant had declined (5). This may indicate that, in the Netherlands, a number of euthanasia requests persist even when full palliative care is available. Nevertheless, in 2005, 1.7% of all deaths in the Netherlands resulted from voluntary euthanasia, down from 2.6% in 2001. The decline in voluntary euthanasia rates was attributed to a replacement of voluntary euthanasia and physician-assisted suicide by continuous deep sedation (49). Diverging attitudes of physicians toward euthanasia and physician-assisted suicide can be explained, at least in part, by the factors of age, speciality, gender, religion, country, and patient characteristics. The age factor includes several elements that could exercise significant influence on attitudes toward euthanasia and physician-assisted suicide. With increasing age, a doctor's years of experience increase. An older physician is likely to have treated more terminal patients. Younger physicians, on the other hand, have generally not been confronted with a deterioration in their own health and may be expected to reflect upon their own death less frequently. Younger physicians may also be less religious than their older colleagues. Although the

importance of these elements may seem obvious in the context of attitudes toward endof-life issues, the pertinence of the age factor age cannot be unanimously confirmed on the basis of a comparison of the studies in this review. A possible explanation for the lack of unanimity in the articles may be that elements such as years of experience as a doctor, number of terminal patients treated, deterioration in one's own health, and reflection on one's own death do not necessarily lead to the same attitude. A doctor who has treated more terminal patients may be able to control pain better and may, therefore, consider euthanasia and physician-assisted suicide superfluous. But, he may also have learned to appreciate the autonomy of a patient or he may have experienced situations in which the suffering of a patient could not be alleviated. Thinking about one's own death may generate a fear to hasten death, but it may also strengthen a desire to ensure control over death.

Physicians are less in favour of euthanasia and physician-assisted suicide than the general public and nurses (24,30,36,37). The greater reluctance of physicians, when compared to the general public, to accept the active hastening of death as a possibility may not only be explained by their more frequent contact with terminal patients, but also by the fact that the physician will finally be accountable for the act and thus for the patient's death, while the general public and, to a certain extent, even nurses are not. The finding that intensive care physicians are more positive toward voluntary euthanasia than geriatricians can be explained by the fact that the dying process of patients on an intensive care unit significantly differs from the gradual deterioration that is often witnessed on geriatric and oncology wards (12,28-30,38). The speciality of a physician could thus also influence his/her attitude toward euthanasia and physician-assisted suicide.

The influence of religiosity on attitudes toward ethical issues related to the end-of-life seems obvious, given the characterization of life as "sacred" within Christianity and other religions. However, the studies reviewed here do not unanimously agree that religion is a decisive factor. Moreover, all studies use a very limited operationalization of religiosity. Religiosity is much more than a statement that one belongs to a certain religious group or that religion is important in one's life. Religiosity includes belief, practice, experience, and knowledge and its consequences in daily life (50). Research that wants to measure adequately the influence of religiosity on ethical attitudes should take all these aspects into consideration. The questions measuring religiosity and worldview in the reviewed articles are generally too vague to yield significant results. Inadequate measuring of the different aspects of religiosity and wordview may have led to overor underreporting the influence of religiosity and worldview on physicians' attitudes. Just as in the age factor, the country factor groups several elements that could be decisive for attitudes toward euthanasia and physicianassisted suicide. Probably religion is the most important element that is also partly covered by the country factor (51). The population of southern Europe is traditionally perceived as more religious and less secular than that of northern Europe. From this follows the hypothesis that people living in southern European countries would be less in favour of euthanasia and physician-assisted suicide than people living elsewhere in Europe. This is, however, not confirmed in the large-scale comparative studies of the EURELD-consortium

(10,12,41). Also, the study by Cohen *et al.* (51) dealing with the European public's acceptance of euthanasia could not establish a clear north-south contrast, although it found that acceptance of euthanasia decreased with increasing levels of religious belief. In reality, religious and ideological differences between north and south Europe are less clear-cut than is often assumed (52). Differences in attitudes between countries may, to a certain extent, be further explained by diverging legal contexts. Maitra *et al.* (23) showed that the willingness to hasten the death of a patient is influenced by legal circumstances. They asked if physicians would be willing to practise euthanasia in the current German context, and whether they would be willing to perform euthanasia, if it were allowed. While 5% of the physicians answered positively on the first question, 18% declared themselves willing to practise euthanasia if this were allowed by German law (23). According to the results published by Miccinesi *et al.* (12), Belgian and Dutch physicians have the most positive attitude toward euthanasia. At present Belgium and the Netherlands are the only European countries that have euthanasia laws. Nevertheless, in Belgium it was certainly not the national Order of Physicians nor any other professional body of physicians that argued or campaigned for the euthanasia law (2,53). Drawing further conclusions based on a comparison between studies is difficult due to diverging methods; different groups of physicians who answered the surveys; a limited focus on southern Europe; and the complete absence of results dealing with eastern Europe. The situation in southern Europe was only discussed in the studies of the EURELD-consortium (10,12,41), and in the articles of Sprung *et al.* (13) and Parpa *et al.* (15). Surveys in southern and eastern European countries about the attitudes of physicians toward euthanasia and physician-assisted suicide could, among other findings, provide interesting results concerning the relationship between these attitudes and religiosity.

CONCLUSION

It is clear that the attitudes of European physicians toward the intentional active termination of life by or with the help of physicians are very diverse. In most studies, a majority of physicians are against any form of active hastening of the dying process, and against the legalization of euthanasia and physician-assisted suicide. But again, making generalizations is difficult. Important differences occur between age groups, nationalities, medical specialities, and religions and worldviews. These differences partially explain the diversity found in the studies. In my opinion, the aim of a medical doctor is to see the very best care for everyone facing the end of life. I think that people who are dying can still live life well, no one has to die in avoidable pain and suffering. Is important take care to whoever needs it, whenever and wherever it is needed. People accept that dying is part of the experience of living.

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