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Doctors' attitudes to assisted dying

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BACKGROUND

Assisted dying is illegal in Norway, but a majority of the population is in favour of legalisation. Doctors' attitudes to assisted dying were last investigated in 1993. Have their attitudes changed?

MATERIAL AND METHOD

Two surveys undertaken among representative panel of practising doctors of the Institute for Studies of the Medical Profession in 2014 and 2016, respectively, included questions about assisted dying. The responses were analysed with the aid of descriptive statistics and logistic regression.

RESULTS

The response rates were 75.0 % (2014) and 73.1 % (2016). The majority was opposed to legalisation of assisted dying. In the 2016 survey, 9.1 % of the respondents reported to 'strongly agree' or 'partially agree' that physician-assisted suicide should be made legal for persons who suffer from 'a fatal disease with short remaining life expectancy'. Younger and non-religious respondents took a positive view of legalisation more frequently than others. In the 2014 survey, 8.6 % of the respondents reported that they would be willing to provide physician-assisted suicide should it be made legal.

INTERPRETATION

As in 1993, a majority of Norwegian doctors were opposed to assisted dying, but now there seem to be more doctors than previously in favour of legalisation in certain cases. Only very few would be willing to provide assisted dying themselves in the event that it should it become permissible.

Assisted dying is illegal in Norway, but surveys indicate that a majority of the population is in favour of legalisation (1). However, the issue of legalisation has not yet appeared on the political agenda. One reason for this could be that the traditional opposition to assisted dying among the healthcare professions has been a key premise for this debate: The Norwegian Medical Association and the Norwegian Nurses Organisation are both opposed to legalisation. Previous studies have indicated that doctors and medical students are more negatively inclined to legalisation than the population in general (2, 3). Furthermore, research indicates that illegal euthanasia occurs very rarely in Norway (3, 4).

Some countries and states have legalised assisted dying in various forms. Both euthanasia and physician-assisted suicide are legal in the Netherlands, Luxembourg, Canada and Colombia. Euthanasia is permitted in Belgium, physician-assisted suicide is permitted in some states in the USA, and Switzerland is making provision for assisted suicide. In the autumn of 2017, the Australian state of Victoria decided to legalise euthanasia from 2019 (5). However, there is no clear international trend towards liberalisation: in a number of jurisdictions, for example England and Scotland, parliamentary bills for legalisation have been rejected after extensive debate.

In many countries, the medical profession's attitude to assisted dying appears to have had an effect on outcomes regarding legalisation. The British Medical Association is opposed to legalisation. In California, the medical association took a neutral stance to the question of physician-assisted suicide in 2015, whereupon the state introduced it the following year (6). In 2014, the Canadian Medical Association replaced the ban on assisted dying with a formulation to the effect that doctors should be permitted to 'follow their own conscience' in this issue. Assisted dying was legalised two years later (7, 8). It is thus also of political interest to identify Norwegian doctors' attitudes to this issue.

In this article we use 'assisted dying' as a collective term for 'euthanasia' and 'physician-assisted suicide', which is defined in line with the definitions of the European Association of Palliative Care: *Euthanasia* is the intentional killing of a person by a doctor who injects lethal drugs in response to a voluntary request from the person. *Physician-assisted suicide* is suicide committed with the help of a doctor, who provides drugs that the person can take him- or herself. Assisted dying must be distinguished from non-treatment decisions, which is to

withdraw or not initiate potentially life-prolonging treatment of patients who are seriously ill or in the final stage of life (9).

In debates on ethics, the terms used can be value-laden and controversial, and this is not least the case in the debate on assisted dying. It has been shown that the terms and descriptions used in surveys of attitudes, as well as the context and order in which the questions are posed, may influence responses (1). In light of this, previous surveys of attitudes have been criticised for imprecise definitions and biased formulation of questions (1, 2). In a survey ("Medievaneundersøkelsen") undertaken by Respons Analyse in 2015 it was reported that 28 % of doctors were in favour of legalising assisted dying (10). However, only one question was asked, the expression 'assisted dying' was not introduced or defined, and the situations in which this should be made legal were not specified. Another previous study of doctors' attitudes to assisted dying, undertaken in 1993 and published in 1997, also has some weaknesses (3). Key questions and responses from this study are summarised in Box 1.

Box 1 Survey undertaken in 1993 on doctors' attitudes to assisted dying (3)

'Life is coming to an end for a patient suffering from a painful and incurable disease. The patient requests the doctor's help to die. Do you think that the doctor should be permitted to end the patient's life in a painless manner (voluntary euthanasia for a terminal condition)?' 17 % answered yes, 65 % no, 18 % undecided.
'A patient is suffering from an incurable disorder that causes chronic pain, great discomfort and strongly reduced ability for self-realisation. The patient has a well-considered desire to die, and requests the doctor's help to do so. Do you think the doctor should be permitted to end the patient's life in a painless manner, even if the patient might have more years left to live (voluntary euthanasia in a non-terminal condition)?' 4 % yes, 84 % no, 12 % undecided.

We wanted to investigate Norwegian doctors' attitudes to assisted dying anew, this time with more precise and neutral terms and formulations of questions.

Material and method

Our analyses are based on data from surveys undertaken by the Institute for the Study of the Medical Profession in 2014 and 2016. Every second year, the institute conducts a postal questionnaire survey among a representative sample of Norwegian doctors (The Physician Panel), asking about doctors' health, working conditions and attitudes to various aspects of their professional activity, such as ethical issues. The sample represents an unbalanced cohort, since participants who leave the panel are replaced by younger doctors, while the representativeness of the sample is maintained. Representativeness in terms of age, gender and specialty is checked against the membership register of the Norwegian Medical Association, of which more than 95 % of all Norwegian doctors are members.

The questionnaire used in 2016 consisted of several sections, and the section 'Ethics, politics and religion' introduced the terms assisted dying, euthanasia and physician-assisted suicide and defined them in line with the definitions given above before the respondents were asked to adopt a position on four assertions about assisted dying in different situations. Possible responses were 'strongly agree', 'partially agree', 'neither agree, nor disagree', 'partially disagree' and 'strongly disagree' for each of the questions. The respondents had also reported their gender, age and medical specialty and answered the question 'How important is your religious conviction for you in your profession as a doctor?'

Using logistic regression analysis, we sought to identify the factors that predicted attitudes to legalisation. We dichotomised the responses, so that 'agree' included both 'strongly' and 'partially, and 'disagree' encompassed the remaining response alternatives.

In the 2014 survey, the doctors were asked to state their view of whether they would be willing to perform various interventions that could entail potential ethical dilemmas. The question that is relevant for our study was whether the respondent would have performed physician-assisted suicide in the event that this should be made legal. The response options were 'yes', 'no' and 'don't know'.

Participation in the surveys was voluntary and based on informed consent. The Regional Committee of Medical and Health Research Ethics (REK) has exempted this study from evaluation.

STATISTICS

The responses were analysed using IBM SPSS Statistics 25. Results are presented in a descriptive form as numbers and percentages. Statistical correlations were investigated with the aid of logistic regression analysis.

Results

In 2016, the questionnaire was sent to 2 196 persons, 1 605 of whom responded (response rate 73.1 %). The 2014 questionnaire was sent to 1 545 persons, 1 158 of whom responded (response rate 75.0 %).

In the 2016 survey, 488 (30.7 %) respondents agreed either strongly or partially that 'physician-assisted suicide should be permitted for persons suffering from a fatal disease with a short remaining life expectancy' (Table 1). There was less support for legalisation of euthanasia in a similar situation, and least support for assisted dying in cases of chronic illness.

Table 1

Doctors' attitudes to legalisation of assisted dying (i.e. euthanasia and physician-assisted suicide) in various situations. Survey of The Physician Panel 2016. Number (%).

Assertion	Strongly agree, n (%)	Partially agree, n (%)	Neither agree, nor disagree, n (%)	Partially disagree, n (%)	Strongly disagree, n (%)	Total, n (%)
'Physician-assisted suicide should be permitted for persons suffering from a fatal disease with a short remaining life expectancy.'	145 (9.1)	343 (21.6)	169 (10.6)	181 (11.4)	753 (47.3)	1 591 (100)
'Euthanasia should be permitted for persons suffering from a fatal disease with a short remaining life expectancy.'	126 (7.9)	273 (17.2)	178 (11.2)	195 (12.3)	817 (51.4)	1 589 (100)
'Assisted dying should be permitted also for persons suffering from an incurable chronic disease, but who are not dying.'	61 (3.8)	141 (8.9)	160 (10.1)	209 (13.1)	1021 (64.1)	1 592 (100)
'There are cases in which it may be right/morally defensible for the doctor to provide assisted dying, even though it is illegal.'	100 (6.3)	309 (19.4)	186 (11.7)	201 (12.6)	795 (50.0)	1 591 (100)

Using logistic regression analysis, we investigated the effect of gender, age, religious conviction and specialty on how doctors viewed legalisation of physician-assisted suicide in cases of patients with a fatal disease and a short remaining life expectancy (Table 2). In the adjusted analysis, which is controlled for gender, age and specialty, there was a significant correlation between religious conviction and opposition to permitting legalisation of physician-assisted suicide, compared to those who did not harbour any such conviction. Higher age was associated with a higher likelihood of opposition to legalisation. There was a significantly higher likelihood that doctors in laboratory medicine and community medicine would favour legalisation than general practitioners and specialities with direct contact with patients, all other factors kept constant. This did not apply to the other specialties.

Table 2

Odds ratio (OR) for the effect of gender, age, religiosity and specialty for whether doctors would strongly or partially agree to legalisation of physician-assisted suicide for persons with a fatal disease and short remaining life expectancy (n = 1 499).

	Unadjusted analysis			Adjusted analysis		
	OR	(95 % CI)	P-value	OR	(95 % CI)	P-value
Gender						
Men	1			1		
Women	1.05	0.84–1.31	0.65	0.78	0.61–1.00	0.05
Age	0.98	0.97–0.98	< 0.001	0.97	0.97–0.98	< 0.001
Significance of religious conviction						
Little significance	1			1		
Large/some significance	0.18	0.12–0.28	< 0.001	0.20	0.13–0.30	< 0.001
Specialty						
General practice	1			1		
Internal medicine	1.18	0.87–1.60	0.29	1.11	0.81–1.52	0.53
Surgery	1.32	0.95–1.84	0.10	1.28	0.91–1.80	0.16
Psychiatry	1.07	0.72–1.59	0.74	1.24	0.82–1.88	0.31
Laboratory medicine/community medicine/other	1.56	1.07–2.25	0.02	1.55	1.05–2.27	0.03

We have also undertaken logistic regression analyses to investigate the effect of the same factors for the remaining questions. The correlation of *not* wanting 'to permit euthanasia for persons with fatal disease and short remaining life expectancy', was significant for women (0.66, 95 % CI 0.51–0.86), older doctors (0.97, 0.96–0.98) and respondents with a religious conviction (0.24, 0.15–0.37). Similarly, a significant correlation was shown between *not* wanting 'assisted dying to be permitted also for persons suffering from an incurable chronic disease, but not dying' and being a woman (0.61; 0.43–0.84), older (0.97; 0.95–0.98) or having a religious conviction (0.28; 0.15–0.52).

We asked the respondents to adopt a position on the following assertion: 'There are cases in which it may be right/morally defensible for the doctor to provide assisted dying, even though it is illegal.' Altogether 409 respondents (25.7 %) strongly or partially agreed, while 996 (62.6 %) strongly or partially disagreed (Table 1). A total of 112 (12.0 %) of the 931 respondents who were opposed to legalisation of physician-assisted suicide nevertheless answered that it might be right/morally defensible to provide assisted dying although it is illegal.

If assisted dying were to be made legal, would doctors be willing to provide it? In the 2014 survey they were asked whether or not they would have performed physician-assisted suicide in the event that this should be legalised. Only 96 doctors (8.6 %) answered 'yes',

while 757 (68.2 %) answered 'no' and 257 (23.2 %) were undecided.

Discussion

Even though the majority of the doctors were opposed to permitting assisted dying, it is worth noting that as many as 30.7 % of the doctors agreed partially or strongly that assisted dying ought to be permitted for persons who are fatally ill and have a short remaining life expectancy. This is as large a proportion (31 %) as among fifth- and sixth-year medical students who were questioned about this issue in 2012 (2). A considerably higher number of doctors (12.7 %) than medical students (5 %) were in favour of assisted dying in cases of chronic illness. However, the medical students did not have the opportunity to be more specific in their response of 'agree' or 'disagree'.

Our study provided the respondents with the opportunity to be more specific, but this also opens room for interpretation: what does it mean to 'partially agree' or 'partially disagree' that assisted dying ought to permitted? Would all these respondents have answered either 'agree' or 'disagree' if these had been the only response alternatives? In our analyses we have assumed that the respondents were either in favour of or opposed to legalisation, but it is reasonable to assume that the specific design of a law on assisted dying would influence these doctors' opinions. They would probably be more receptive to arguments in favour of or against legalisation than those who chose the extreme responses. Viewed in this perspective, a large proportion of Norwegian doctors appear not to have had an unshakeable opinion, but might be willing to change their views on the issue of assisted dying.

Comparisons with previous surveys are made difficult by the fact that definitions and formulations of the questions differed. However, to the extent that the 1993 survey (Box 1) was biased, our interpretation is that it tended to sway the respondents towards taking a positive view of legalisation. In our view, the distinction between assisted dying and decisions to withhold treatment seemed somewhat unclear, and assisted dying was portrayed in a positive light by charged phrases such as 'help to die', 'well-considered' and 'painless manner' (3). Since there was more support for assisted dying in 2016 than in 1993, despite the possibility that the formulations in 1993 may have swayed the respondents towards a positive answer, we believe that there is reason to assume that there has been a real change of opinion among doctors.

Nonetheless, doctors are still considerably less in favour of legalisation than the population in general. In 2015, the three first questions in Table 1 were also posed to a sample of the population (1). To the assertion that 'physician-assisted suicide should be permitted for persons suffering from a fatal disease with a short remaining life expectancy', 37.5 % responded 'strongly agree', 35.6 % 'partially agree', 7.3 % 'neither agree, nor disagree, 6.7 % 'partially disagree' and 12.9 % 'strongly disagree'. The majority (66.5 %) also agreed strongly or partially to the assertion regarding euthanasia in case of fatal illness, while 37.9 % agreed strongly/partially to the assertion concerning assisted dying in cases of chronic illness. Please note, however, that the survey had a low response rate.

With the assertion that 'there are cases in which it may be right/morally defensible for a doctor to provide assisted dying, even though it is illegal' we wished to investigate whether doctors who were opposed to legalisation would nevertheless think that there might be situations in which such an act could be appropriate. While one-quarter of all respondents believed that assisted dying may sometimes be appropriate in spite of being illegal, this view was also shared by 12 % of those who were *opposed* to legalisation. On the other hand, the majority of the respondents report that they would not have provided assisted dying, even in a situation where this was permitted.

These findings probably reveal something both about the way in which doctors perceive assisted dying as a dilemma in terms of professional ethics and about their attitude to healthcare legislation. Although an act may be illegal and generally regarded as unethical,

there might be extreme situations where healthcare personnel feel that the law and the ethical norm have unreasonable consequences and that there are good grounds to violate them in order to do what is perceived as appropriate for the individual patient. Doctors face dilemmas that are caused not only by value conflicts, but also by role conflicts (11, 12). Doctors fill at least four – potentially conflicting – roles: as society's gatekeeper with responsibility for ensuring that laws are abided by and resources fairly distributed, as the patient's spokesperson, as a professional and as a private individual. In special situations, a small minority of doctors might be willing to break the law or refuse to implement statutory practices (11). A study from 2014 indicated, however, that very few Norwegian doctors have provided assisted dying and thus transgressed the boundaries of the law (4).

The strength of this study is that a representative sample of Norwegian doctors have been asked, and that the response rate is high. The challenge is that although we have sought to use precise definitions, our questions and response alternatives nevertheless leave room for interpretation. For example, we cannot know how the respondents interpreted 'short remaining life expectancy'.

Conclusion

A majority of Norwegian doctors were opposed to assisted dying, but the study indicates that the proportion in favour of legalisation has increased since 1993. Considerable weight has been attached to doctors' attitudes to this issue in the political processes in some jurisdictions internationally. The opposition of healthcare professions to legalisation has probably been a weighty argument for politicians not addressing this issue in Norway. Without support from key healthcare professions and their associations, it is difficult to envisage the introduction of assisted dying.

MAIN MESSAGE

The majority of Norwegian doctors were opposed to assisted dying, in contrast to the population in general

A minority of the doctors who were opposed to legalisation were of the opinion that in certain cases, assisted dying may be morally defensible

Few doctors were willing to provide assisted dying

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