

## Original article

# Attitudes toward euthanasia of physician members of the Italian Society for Palliative Care

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### Summary

**Background:** The problems related to requests for euthanasia by terminal patients; the variations in attitude of palliative care physicians and the possibility that availability of the best palliative care might obviate the problem by eliminating requests for euthanasia, are under discussion.

**Design:** A mailed survey with no possibility of follow-up of all 685 physician members of the Italian Society for Palliative Care (SICP) in 1994.

**Results:** Of the 359 (52.4%) responders, 139 (39%) had received requests for euthanasia; 16 of them (4% of the responders but 11.5% of those who received requests) had complied at least once, while 216 (60%) had not; 125 (35%) thought that euthanasia was 'wrong' under all circumstances; 115 (32%) thought that situations could occur, even in the

context of palliative care, in which euthanasia might be ethically 'correct'; 185 (52%) thought that the best palliative care might solve the problem of euthanasia, while 109 (30%) believed otherwise. The variable most strongly associated with a negative attitude toward euthanasia and with the opinion that the best palliative care might be a solution to the problem is religious belief ( $P < 0.0001$ ).

**Conclusions:** The attitudes of physicians practising palliative care in Italy are not different from those reported by previous studies which investigated the attitude of other health professionals. There was no agreement about whether the best palliative care might reduce requests for euthanasia by terminal patients.

**Key words:** attitudes, cancer, ethics, euthanasia, palliative care

### Introduction

The increase in applied high technology in the medical field has prolonged the dying process at the expense of an acceptable quality of life and of a dignified death. Faced with the choice of life-prolonging treatments, physicians often administer therapies against the wishes of the patient. The patients may assert their right to participate in decisions concerning their life, to the point of requesting euthanasia, and most ethicists contend that it is morally difficult to justify denying this right [1, 2]. The Hospice movement and palliative care medicine propose the principles of total care (physical, psychological, social, spiritual) [3] as the proper approach to solving the problem of interrupting the life of terminal and suffering patients (the situation in which requests for euthanasia occur most frequently), but no studies show that palliative care reduces the number of request for euthanasia. On the contrary, the view that hospice care stems the desire to die sooner or to be euthanized has little support [4].

The aim of this study was to investigate the requests of terminally-ill patients for euthanasia, to examine the attitudes of palliative care physicians toward active euthanasia, and the possibility that best palliative care would solve the problem.

### Patients and methods

A questionnaire was mailed to all physician ( $n = 685$ ) members of the Italian Society for Palliative Care (SICP) in 1994 – mainly anaesthetists, pain therapists and oncologists, all involved in the care of terminal cancer patients. The questionnaire contained five questions concerning:

1. the request for euthanasia by terminally-ill patients;
2. their willingness to act upon the patient's request;
3. whether they responded positively by an act of active euthanasia;
4. their attitude *versus* the ethical-legal positions on euthanasia;
5. the possibility that even with the best palliative care the problem would still exist.

Questions 4 and 5 were partially adapted from the Academy of Hospice Physicians' (AHP) questionnaire on euthanasia and assisted suicide [5].

To avoid misunderstandings about the word 'euthanasia', the following definition was given in the questionnaire:

Any act, medical or not, which intentionally interrupts or shortens the life of an ill person – in the terminal stage of a disease with a negative prognosis – who is of sound mind and who made the request voluntarily.

Personal and professional data was requested: sex, age, religion, number of years of activity in palliative care and number of patients cared for with palliative care until death.

To guarantee anonymity, data was collected through a notary office. The notary was able to check the validity of the questionnaires which were returned but not the responses, while the researchers were able to analyse the data obtained but not their origin.

After the first mailing (February 1994), two reminders were sent out (May and October 1994). By March 1995, 385 completed questionnaires had been returned. Two questionnaires were eliminated as incomplete and a further 24 were not considered valid as the responders did not qualify as part of the population investigated. Thus, 359 questionnaires (52.4%) were analyzed.

The analysis of the bivariate association between the responses to questions 4 and 5 (dependent variables) and the personal and professional variables (independent or explicative variables), was carried out with the Kruskal–Wallis non-parametric test [6]. A multivariate analysis of partial association for each of the independent variables was performed with the Kruskal–Wallis test adjusted for the explicative variables found to be significantly associated with the bivariate analysis [7]. All of the tests were two-tailed with significance levels of 0.05.

The responses in questionnaires with data missing on two or more variables were excluded from the analyses which included those variables.

The representativeness of the responder sample in comparison with all SICP members was not evaluated, because the characteristics of the members were not available.

## Results

Of the responders to the questionnaire the majority were: male (69%), 36–45 years old (49%), religious (73%) and averaged 6.5 years work in palliative care (Table 1).

Of the 359 physician responders 216 (60%) said they had never received a request for euthanasia from a terminal patient, while 139 (39%) said they had; 16 (4% of the respondents but 11.5% of who received requests) said they had practised euthanasia at least once and 20 (6%) said they were willing to comply if requested by the patient; 125 (35%) were in favour of the statement that euthanasia was 'wrong' under all circumstances, and 115 (32%) thought the contrary – that situations might exist in palliative care in which euthanasia may be ethically right; 185 (52%) thought that

Table 1. Demographic and professional characteristics of the 359 responders to the questionnaire.

	No. responders <sup>a</sup>	%		
Sex				
Male	249	69		
Female	107	30		
Age				
26–35	76	21		
36–45	176	49		
>45	105	29		
Religious				
Yes	261	73		
No	84	23		
Patients followed personally in palliative care until death from the beginning of professional activity				
<100	165	46		
>100	179	50		
	Range	Average	Median	Q1–Q3
Years of experience in PC	0–30	6.5	5	3–8

<sup>a</sup> 2–15 (0.5%–4%) missing at each item.

the problem of euthanasia could be overcome by offering patients the best palliative care; 109 (30%) said there would still be a problem (Table 2).

## Association analysis of dependent and independent variables

The responses to question 4 (Table 3) are strongly associated with religious belief ( $P < 0.0001$ ): distribution of the responses of the religious group is oriented more toward the view of euthanasia as 'wrong' than in the non-religious. The same responses show an association with age and follow a non-monotonous trend: the responses of the youngest and the oldest tend to point to euthanasia being 'wrong under all circumstances', as 55.4% and 42.3%, respectively, answered 'A' to question 4, while the middle-aged range tended to consider euthanasia as 'ethically right in some situations', with 43.4% answering 'D' ( $P < 0.01$ ).

Table 2. Frequency distribution of responses to the questionnaire.

	No. responders <sup>a</sup>	%
1. Have you ever received a request for euthanasia from a terminal patient?		
Yes	139	39
No	216	60
Prefer not to answer	4	1
2. If yes, have you complied at least once? (Base 359)		
Yes	16	4
No	110	31
Prefer not to answer	2	1
3. If a terminally-ill patient asked you to inject a lethal dose of a drug, would you consent?		
Yes	20	6
No	269	75
Don't know	60	17
Prefer not to answer	5	1
4. Which of these statements are you in favour of?		
(A) Euthanasia is 'wrong' under all circumstances	125	35
(B) There's no room for euthanasia in the medical profession	39	11
(C) Euthanasia must not be practised by physicians in palliative care, but I recognise society's right to develop guidelines on it in other contexts	44	12
(D) There may be circumstances in palliative care in which euthanasia may be ethically 'right' for physicians	115	32
None of the above	13	4
Other	9	2
5. Do you think that if terminal patients had the best palliative care there would be no problem of euthanasia?		
Yes (No longer a problem)	185	52
No (There would still be a problem)	109	30
Don't know	61	17

<sup>a</sup> 0–14 (0%–4%) missing at each item.

There was no evidence of an association with other variables considered.

The study of partial association confirmed the results of the bivariate analysis: religious belief and age were found to be significantly associated with responses to question 4 after adjustments for age and religion, respectively. In particular, from the analysis of the partial frequency distributions, the association between the responses to question 4 and age is clear in the religious group but not in the non-religious. This shows that while not being religious is the only determinant of the position on euthanasia as being right or wrong, for the non-religious age also plays a role in determining the position towards euthanasia, in accord with the trend seen in the bivariate analysis.

Responses to question 5 (Table 4), apart from being significantly correlated with the fact of being religious or not ( $P < 0.0001$ ), show a significant correlation with sex difference ( $P = 0.033$ ). Among those with religious

faith as opposed to the non-religious, as well as among men as opposed to women, the opinion expressed was that the best palliative care can solve the problem of euthanasia. In this case the multivariate analysis, in addition to confirming the correlation with religious faith and sex difference in responses to question 5, also highlighted the relationship with the number of years of experience in palliative care. In fact, while for the non-religious there is no substantial difference in sex and number of years of practice in palliative care in their responses to question 5, for the religious, the men as opposed to the women and those who have practised palliative care for longer than five years as compared to those who have practised for less, were more inclined to believe that better palliative care might resolve the problem of request for euthanasia.

An examination of the distribution of the responses to the questionnaire and the personal and professional characteristics of the sixteen physicians who admit to having practised euthanasia at least once, shows that in comparison to the overall group of responders ( $n = 359$ ) the majority were not religious (56% versus 23%), were male (81% versus 69%), belonged to the second (56% versus 49%) and third age categories (38% versus 29%) and had practised palliative medicine for an average of 9.3 years (versus 6.4 years). This comparison is merely descriptive, but is interesting because it shows that the subgroup of 16 physicians differs from the total group of responders, and the differences reflect the conclusions of the association analysis between the responses to questions 4 and 5 and the personal and professional characteristics.

Regarding the responses to other questions, 81% of the 16 physicians responded with 'D' (euthanasia is 'right') to question 4; 50% do not believe that better palliative care can eliminate the problem of euthanasia (but 30% do and 19% are undecided) and 37% would practise euthanasia if the patient requested it of him or her (25% said no and 31% did not respond).

Table 3. Distribution (%) of socio-professional variables of responses to question 4: 'Which of these statements are you in favour of?'

Variables	Category	Question 4				$P^a$	$P^b$
		A	B	C	D		
Sex	Male	36.7	13.1	13.5	36.7	0.398	
	Female	42.9	9.9	14.2	33.0		
Age	26-35	55.4	13.8	7.7	23.1	0.001	0.002
	36-45	29.5	12.0	15.1	43.4		
	>45	42.3	10.3	15.4	32.0		
Religious	Yes	50.0	15.0	11.1	23.9	0.0001	0.0001
	No	5.2	5.2	22.1	67.5		
No. patients	<100	41.4	12.4	11.0	35.2	0.35	
	>100	35.0	11.0	17.0	37.0		
Years of experience in palliative care	<5	40.2	14.0	14.0	31.8	0.28	
	>5	37.8	9.6	11.1	41.5		

<sup>a</sup> Kruskal-Wallis test.

<sup>b</sup> Stratum-adjusted Kruskal-Wallis test.

Table 4. Distribution (%) of socio-professional variables of responses to question 5: 'Do you think that if terminally-ill patients had the best palliative care there would not be the problem of euthanasia?'

Variable	Category	Question 5			$P^a$	$P^b$
		No	?	Yes		
Sex	Male	28.1	15.8	56.1	0.033	0.045
	Female	36.8	19.8	43.4		
Age	26-35	33.3	20	46.7	0.229	
	36-45	30.7	19.3	50		
	>45	27.4	11.8	60.8		
Religious	Yes	46.4	17.9	35.7	0.0001	0.001
	No	24.8	17.8	57.4		
No. patients	<100	28.4	18.8	52.8	0.51	
	>100	35.1	13.2	51.7		
Years of experience in palliative care	<5	32.3	19.3	48.4	0.078	0.022
	>5	27.4	13.1	59.5		

<sup>a</sup> Kruskal-Wallis test.

<sup>b</sup> Stratum-adjusted Kruskal-Wallis test.

## Discussion

Although further investigations are necessary [8], an attitude may grow and ripen because of the particular context in which a nurse or physician works. It has been shown that 'euthanasia' is more accepted in neonatology units where, paradoxically, death is less tolerable, while it has been seen that the dominant professional culture in palliative care services is generally anti-euthanasia [9].

In the field of incurable illnesses some physicians' attitudes must be considered in light of the difficulty they encounter when approaching dying patients [10, 11] and the challenge these patients represent, which can be characterized as one of 'medical omnipotence' [12]. Although the attitudes of many physicians are today positive towards palliative medicine and supportive care, the number of physicians more favourable to

assisted suicide and/or euthanasia is increasing [13–17]. The percentage of physicians who approve of euthanasia and assisted suicide ranges from the 35%–43% (only oncologists) reported in *Lancet* [18] to 46% of the Oregon State physicians [19], 56% of the Michigan State physicians [20], 59% of New South Wales, Australia, physicians [21] and 88% of Netherlands physicians [22]. This is in agreement with the findings for the general population [23–25] and has been further emphasised in other studies [26, 27] which conclude by observing that – apart from a polarisation of the for/against euthanasia factions – there is an increased tendency by physicians to follow through on the patient's request for euthanasia and/or assisted suicide. The same conclusions may be drawn from a study which pointed out that although only 1.1% of physicians admit having administered a lethal dose of a drug to a suffering patient, the majority tends to accept the principle of using techniques which would reduce the length of time of the patient's suffering or survival in instances of incurable disease, thus affirming the self-determination principle [28].

Because of the low percentage of physicians involved in the care of the terminally ill, which emerged in all of these studies, we thought it of major importance to carry out a study focusing on a wide sample of palliative care physicians (the characteristics of the sample – including only physicians who cared for mainly terminal cancer patients – is particularly interesting because of the constant contact these physicians have with suffering and imminent death), considering whether only particular variable could affect the palliative care physicians' attitudes, some of which may be considered predictors of negative or positive attitude toward euthanasia.

This survey has pointed to variables already revealed in other studies, such as sex difference [29], religion [19, 20], previous experience in withdrawal of therapy and number of years of experience in the health service [30, 31] and also an increased tendency of the younger and older physicians to be in favour of euthanasia. Compared with studies carried out in other fields, a variable such as religion must be particularly considered in relation to the prevailing faith of the Italian population, which adheres to the Roman Catholic doctrine which is traditionally opposed to the taking of an innocent human life in any circumstances.

With respect to the number of questionnaires completed, it is reasonable to think that the large number of non-responders is due to the nature of the argument, which may solicit a refusal, as well as the more general tendency of many people not to participate in mailed surveys [32, 33]. However, the results of the present study must be interpreted with caution, because of the possible selection of the sample which could have been caused by the non-response process.

A statement issued by the European Association for Palliative Care (EAPC), says that the debate about the legalisation of euthanasia or whether it is 'right' could

be overcome by the application and implementation of adequate palliative care [34]. However, from the results of our study emerged the fact that a considerably high percentage of palliative care physicians had received requests for euthanasia from patients in the terminal phase of illness. This data raises not only an important epidemiological issue, but an ethical problem as well. The ethical problem is further emphasized by the 16 physicians who said that they had carried out euthanasia, 6 of whom would do it again and another 14 who would be willing to do so.

This study therefore underscores the fact that a satisfactory solution to the problem has not yet been found in the field of palliative care in Italy. In fact, even though the physicians' response concerning elimination of the problem of euthanasia, should better palliative care be introduced, tends towards the affirmative (52%), a third of the responders answered negatively.

This result is very close to that found by the Academy of Hospice Physicians (AHP) which carried out two studies on euthanasia and assisted suicide on members of the AHP. The results presented during the 1991 annual meeting of the AHP – but not published – yielded percentages of members of the AHP as being against euthanasia (53% against and 39% for) similar to those we found.

## Conclusions

Even though the percentage of palliative care physicians who completed the questionnaire in our study and who would practise active euthanasia is much lower (6%) than that reported by studies on medical populations in general – about 30% – [18, 20, 24], our data are in accord with those of studies recently carried out [19, 20] which show that the specialty of physicians involved in the care of terminally ill patients was not a significant predictor of their attitudes towards euthanasia and that religion is a very important variable, as those with strong religious feelings are the ones who are most against euthanasia. Thus, a high percentage of palliative care physicians, even in a predominantly Catholic country like Italy, are not against euthanasia and some of them feel that adequate palliative care would not solve the problem.

What emerges from our study is not the result of a generic investigation into euthanasia carried out in terms of 'for-or-against', 'pro-legalisation-or-not', but rather a clarification of aspects often overlooked in the debate, factors associated with a pro- or contra-euthanasia behaviour of physicians working closely with suffering and imminent death. We wish to emphasize that the little that is known about the variables which influence this critical choice, the use of terms which may be unclear – often 'euthanasia' is used to imply contradictory notions – the emotional factors which are always present when illness, suffering and death are involved [35], all require careful handling in a research project,

limitation in the field of study and an accurate analysis of the results.

We would also like to state, in concordance with other physicians involved in the care of terminal cancer patients, that reducing pain and suffering, improving communication and relations with the dying as well as his/her quality of life, as required by the principles of the Hospice movement and palliative care medicine, can also be the appropriate way to deal with the problem of euthanasia and to provide the terminally ill patient with choices.

### Acknowledgments

We are grateful to the Floriani Foundation Research and Documentation Center for support and advice, and to Mrs Miriam Vigotti for assistance in the translation of the manuscript.

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Received 17 June 1996; accepted 17 September 1996.

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