

Voluntary euthanasia in Northern Ireland: general practitioners' beliefs, experiences, and actions

KIERAN J McGLADE

LOUISE SLANEY

BRENDAN P BUNTING

ANTHONY G GALLAGHER

SUMMARY

Background. *There has been much recent interest in the press and among the profession on the subject of euthanasia and physician-assisted suicide. The BMA recently conducted a 'consensus conference' over the internet to collect views on physician-assisted suicide. Any surveys to date have addressed a variety of specialties; however, no recent surveys have looked at general practitioner (GP) attitudes and experiences.*

Aim. *To explore the attitudes of GPs in Northern Ireland towards the issue of patient requests for euthanasia, their nature, and doctors' experiences of such requests.*

Method. *An anonymous, confidential postal survey of all (1053) GP principals in Northern Ireland.*

Results. *Seventy per cent of responders believe that passive euthanasia is both morally and ethically acceptable. Fewer (49%) would be prepared to take part in passive euthanasia. However, over 70% of physicians responding consider physician-assisted suicide and voluntary active euthanasia to be wrong. Thirty per cent of responders have received requests from patients for euthanasia in the past five years. One hundred and seven doctors gave information about these requests. Thirty-nine out of 54 patient requests for passive euthanasia had been complied with, as had one of 19 requests for physician-assisted suicide and four out of 38 patient requests for active euthanasia. Doctors perceived the main reasons why patients sought euthanasia was because of fear of loss of dignity and fear of being a burden to others.*

Conclusions: *While the majority of GPs support passive euthanasia, they, in common with those who approve of assisted suicide and active euthanasia, often express a reluctance to take part in such actions. This may reflect the moral, legal, and emotional dilemmas doctors encounter when facing end-of-life decisions.*

Keywords: *euthanasia; general practitioner attitudes; patient attitudes.*

Introduction

THE euthanasia debate is likely to gather further momentum in the United Kingdom (UK) with the recent BMA Physician Assisted Suicide Conference Project. Given the trends for shorter hospital stays, the primary care-led service, and increasing sophistication of community palliative care, general practitioners (GPs) are a prime group to encounter requests for euthanasia. Previous studies have examined the attitudes and experiences of hospital- and community-based doctors.^{1,2} Very little data exist on GPs' experiences of requests and their attitudes towards euthanasia.³ This study set out to assess not only GP attitudes, experiences, and perceptions of patient requests for euthanasia but also to determine how GPs behaved when faced with these requests.

The case of Kervorkian in the USA, who has helped at least 130 people to die since 1990, has elicited strong but divided feelings from society in general and from doctors in particular.⁴ End-of-life decisions raise many complex and important issues of increasing relevance to society. There are several possible reasons for this. Owing to advances in medical knowledge and technology, the medical profession now exercises greater control over life and death issues and the dying process itself may be prolonged. However, there may be significant pain and suffering associated with this longevity with increasing psychological distress among patients and relatives. While there is agreement in the medical profession that there is no absolute duty for doctors to prolong life, there is a dilemma regarding the most appropriate stage to forgo active treatment. Furthermore, faced with a patient's request for assistance in hastening death, how do doctors reconcile the relief of suffering, the desire to respect patient autonomy, and their own moral and ethical stance?

Method

A four-part questionnaire was sent to all (1053) GPs on the Principal List in Northern Ireland. The questionnaire, which was piloted among GPs in one large health centre, was based on earlier surveys¹⁻³ and aimed to combine: (a) a survey of attitudes doctors held about euthanasia issues, with (b) an inquiry into how physicians actually behaved when confronted with requests from patients for euthanasia, and (c) case histories of requests for euthanasia. The first part of the questionnaire sought information about basic socio-demographic details of the GP, including religious affiliation and details about the practice setting.

In the second section definitions of passive euthanasia, physician-assisted suicide, and voluntary active euthanasia were provided (Figure 1). Responders were then asked how much they agreed or disagreed with statements about the moral or ethical justification, whether the particular practice should be legal, and whether they would be prepared to participate in each of the forms of euthanasia. A further question asked about changes in attitudes to euthanasia over the past five years and another about the usefulness of 'living wills'. The five-point Likert scale ranged from 'strongly agree' to 'strongly disagree' but for clarity these were collapsed into three categories: strongly agree or agree, neutral and disagree, or strongly disagree.

KJ McGlade, MD, MRCP, senior lecturer in general practice; L Slaney, BSc, student, Dept of Psychology; and AG Gallagher, PhD, lecturer in psychology, Queen's University Belfast. BP Bunting, PhD, lecturer in psychology, University of Ulster.

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Passive euthanasia	Withdrawing or withholding life-sustaining and life-prolonging treatment.
Physician-assisted suicide him/herself, e.g. writing a prescription for a lethal dose of drugs.	Intentionally providing the means or instruction by which the patient could kill
Voluntary active euthanasia overdose.	Taking active steps yourself to bring about the patient's death, e.g. administering a lethal

Figure 1. Definitions provided to GPs participating in the survey.

The third part of the questionnaire asked the GPs for details of requests they had received from patients for euthanasia; whether explicit or tentative, the form of euthanasia requested, and whether the practitioner had actually participated in any form of euthanasia.

In the final section, doctors were asked to consider the most recent request they had received for euthanasia and to give details, including the age and sex of the patient, the diagnosis, and the prognosis. They were then asked to enumerate the main concerns they perceived in the patient that led to the request, the nature of the request, whether the doctor consulted colleagues, and what action was taken.

Responders

Four hundred and thirteen of 1053 questionnaires were returned after the first and only mailing. Of these, 401 were adequately completed, representing a 38% response rate. Because of the sensitive nature of the enquiry it was stressed in a covering letter that no tracing method would be employed and no follow-up questionnaires would be sent. GPs were encouraged to answer only those questions with which they were comfortable. When compared with the demographics from another recent Northern Ireland survey,⁵ which achieved a 90% response rate after repeated mailings, the distributions of age, sex, number of partners, and years since graduation matched very closely.

Results

Doctors' attitudes

Table 1 shows the responses to the attitudinal statements. There were no significant differences in attitude to euthanasia issues with respect to age or sex of doctor or location of practice and no significant differences emerged between the various religious affiliations. However, proportionately more Catholics (20%, $n = 130$) than Protestants and other Christians (9.2%, $n = 217$), felt that their attitudes toward euthanasia issues had changed over the past five years.

Most doctors responding to this survey (70%) believed that passive euthanasia is morally and ethically acceptable. However, significantly fewer (49%) said they would be prepared to participate in passive euthanasia. Most responders believe that physician-assisted suicide and voluntary active euthanasia are wrong (73% and 77% respectively). They also believed that these forms of euthanasia should not be legal. However, a significant minority of practitioners would be willing to participate in physician-assisted suicide (10%) and voluntary active euthanasia (12%). The 'living will' or advance directive was thought to be a positive step in clarifying the situation with regard to voluntary euthanasia by 50% of the responders.

Requests for euthanasia

Thirty per cent of doctors ($n = 118$) reported that they had received an explicit or tentative request in the past five years from a patient to hasten death. Twelve per cent of the practitioners ($n = 46$) had received at least one explicit request.

The doctors were asked to consider the past five years and report what methods patients had requested to end their lives. Figure 2 shows the requests doctors reported they had received (more than one response category could be indicated) and how many doctors had complied with such requests.

Case histories

One hundred and three doctors supplied 'case history' details of the most recent request they had received for euthanasia. Twenty-one of these were repeat requests. Eight per cent of these patients were aged 50 years or less. Doctors were asked to list the concerns they felt patients had that led to them requesting euthanasia. The most common concern cited was 'loss of dignity' (64.7%), followed by 'a burden to others' 54.9%, 'pain' (47.1%), 'physical and mental dependency' (41.2%), and 'loss of control' (37.3%), but other reasons were also cited by patients; 'tired of life', a sense of hopelessness, fear, exhaustion, and the death of a friend among others.

Table 1. Responses from 401 general practitioners to the attitude statements on the questionnaire (%).

Statement on questionnaire	Strongly agree/ agree	Neutral	Disagree /strongly disagree
Passive euthanasia is a morally and ethically wrong act	59 (15)	63 (16)	278 (70)
Physician-assisted suicide is a morally and ethically wrong act	291 (73)	58 (14)	51 (13)
Voluntary active euthanasia is a morally and ethically wrong act	307 (77)	43 (11)	51 (13)
Passive euthanasia should not be legal	64 (16)	69 (17)	268 (67)
Physician-assisted suicide should not be legal	286 (72)	55 (14)	54 (14)
Voluntary active euthanasia should not be legal	300 (75)	44 (11)	54 (14)
I would be willing to participate in passive euthanasia	197 (49)	83 (21)	119 (30)
I would be willing to participate in physician-assisted suicide	42 (10)	46 (12)	311 (78)
I would be willing to participate in voluntary active euthanasia	48 (12)	29 (7)	321 (81)
My attitudes on the euthanasia issue have remained unchanged over the last five years	316 (79)	29 (7)	56 (14)
The 'living will' (or advanced directive) is a positive step in clarifying the situation with regards to voluntary euthanasia	200 (50)	87 (22)	109 (28)

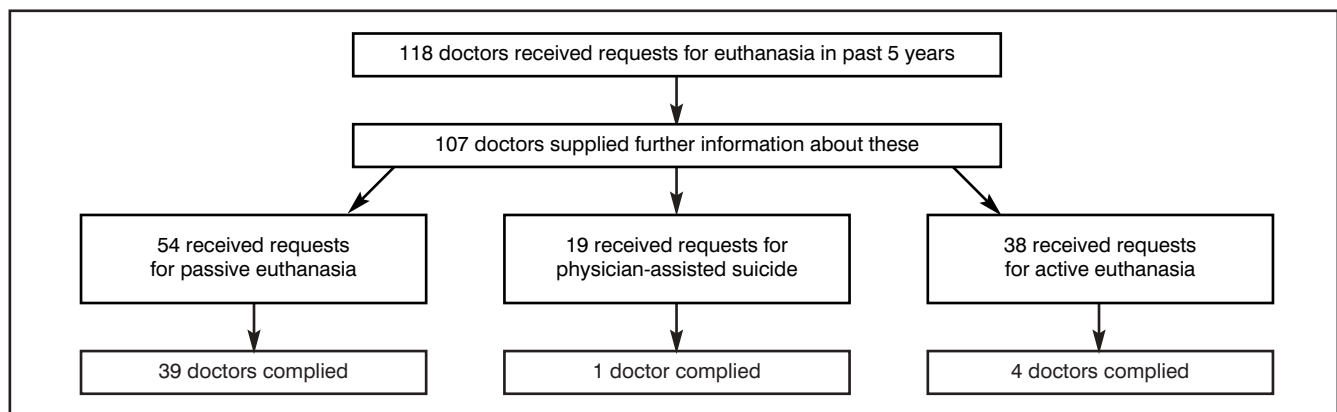


Figure 2. Doctors' experiences of requests for euthanasia over a five-year period.

Of the 103 most recent documented requests for euthanasia 52 were from men and 51 were from women. Those making the requests had an average prognosis of five months (range = 0 to 60 months) and the relevant diagnoses included cancer, multiple sclerosis, Parkinson's disease, arthritis, and stroke.

Doctors were invited to give free text responses detailing the actions they took in following a patient's request. Twenty-one stated that they had ignored the request. Twelve doctors who had practised passive euthanasia completed this section: three stated they had withheld fluids, three had withheld antibiotics, two had withheld other medication, and four said they had complied by 'minimal intervention'. No further details were supplied about actions taken in relation to physician-assisted suicide or active euthanasia.

Discussion

General practitioners are regularly faced with ethical and moral dilemmas, but probably the most deeply felt centre around patients asking for help in ending their lives. This study provides some insight into doctors' attitudes towards pre-defined types of euthanasia and patient-initiated requests for euthanasia.

The number of doctors reporting requests from patients for euthanasia in our study is quite large (30%) and is very similar to the experience reported in Washington State² where 26% of physicians had been requested by patients to hasten their deaths. Other studies have reported higher figures; 60% of hospital doctors and GPs in England³ and 75% of Dutch GPs.⁴ Regional differences may be important and this should be taken into account in any debate.

The 38% response rate in our study would seem, at first, somewhat low. However, given the sensitive nature of the subject and the expressed intention not to follow up non-responders, the response from a single mailing has been very good. The sample size is large and, using indicators such as age, sex, number of partners, and years since graduation, it appears to be representative of GPs in Northern Ireland.

Some stark differences of opinion emerge from the responding GPs. Between 10% and 12% of doctors are willing to endorse physician-assisted suicide and voluntary active euthanasia. However, the vast majority of the doctors responding to this survey (over 70%) believe both assisted suicide and voluntary active euthanasia to be wrong, with less than 20% of doctors taking a neutral position. A significant number of individuals (15%) believe passive euthanasia to be morally unacceptable though most doctors support passive euthanasia (70%). This was, however, much less than a similar study in England³ where 91% of doctors said they were willing to practice passive euthanasia.

Regardless, of these areas of disagreement on what is morally

acceptable, requests for euthanasia are receiving greater public attention. They present particularly acute problems to doctors and we have seen that some have even chosen to ignore these requests. Furthermore, even if a doctor has no moral objections to a particular course of action, the extent of his or her willingness to participate in such an action may be limited. When doctors, who believed that passive euthanasia was morally acceptable, were then asked if they would participate in such an action, only 67% said they would. Indeed, only 28% and 33% of those declaring support for assisted suicide and active euthanasia respectively, said they would be willing to participate in the respective behaviour. A similar reluctance is reported in a national survey of UK psychiatrists' attitudes to euthanasia.⁶ In another Washington State study⁷ 54% of doctors responding thought that euthanasia should be legal in some situations but only 33% said they would be willing to perform euthanasia themselves. Believing that something is acceptable even in terms of one's own value system does not imply a willingness to engage in such behaviour. The death of a patient has emotional consequences for the GP.⁸ This may help account for fewer doctors being willing to participate in even passive euthanasia or other actions for which they have no moral objections. This points to an inherent problem in the conduct of end-of-life decisions. It may be, in time, that doctors may feel a need to declare to patients where they stand on sensitive moral issues, if for no other reason than to minimise areas of potential conflict in the conduct of treatment.

The 'living will' or advance directive was thought to be a positive step in clarifying the situation with regard to voluntary euthanasia by only 50% of the responders. This caution may reflect doctors' awareness of how patients can change their viewpoints. A recent study⁹ has shown that a patient's will to live fluctuates and is 'highly unstable' in terminally ill cancer patients.

Many of the reasons that doctors in our study put forward for patients requesting euthanasia highlight the psychological and social factors (quality of life issues) that can influence intended behaviour and attitudes. The most important perceived reasons for requests for the termination of life concerned issues such as 'loss of dignity', 'being a burden to others', pain, 'physical and mental dependency', and 'loss of control'. In the Washington study,⁷ 21% of the physicians agreed that euthanasia or assisted suicide may be appropriate if external factors (such as not wanting to burden the family or not wanting to deplete savings) led to the patient's request despite adequate pain control and quality of life. Further research is needed on the pressures engendered and on the training doctors may require to cope with the possibility of increasing requests from patients for euthanasia.

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Address for correspondence

Dr KJ McGlade, Department of General Practice, The Queen's University of Belfast, Dunluce Health Centre, 1 Dunluce Avenue, Belfast BT9 7HR.
E-mail: k.mcglade@queens-belfast.ac.uk