

Under what conditions is euthanasia acceptable to lay people and health professionals?

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Abstract

Euthanasia is legal only in the Netherlands and Belgium, but it is on occasion performed by physicians elsewhere. We recruited in France two convenience samples of 221 lay people and of 189 professionals (36 physicians, 92 nurses, 48 nurse's aides, and 13 psychologists) and asked them how acceptable it would be for a patient's physician to perform euthanasia in each of 72 scenarios. The scenarios were all combinations of three levels of the patient's life expectancy (3 days, 10 days, or 1 month), four levels of the patient's request for euthanasia (no request, unable to formulate a request because in a coma, some form of request, repeated formal requests), three of the family's attitude (do not uselessly prolong care, no opinion, try to keep the patient alive to the very end), and two of the patient's willingness to undergo organ donation (willing or not willing). We found that most lay people and health care professionals structure the factors in the patient scenarios in the same way: they assign most importance to the extent of requests for euthanasia by the patient and least importance (the lay people) or none (the health professionals) to the patient's willingness to donate organs. They also integrate the information from the different factors in the same way: the factors of patient request, patient life expectancy, and (for the lay people) organ donation are combined additively, and the family's attitude toward prolonging care interacts with patient request (playing a larger role when the patient can make no request). Thus we demonstrate a common cognitive foundation for future discussions, at the levels of both clinical care and public policy, of the conditions under which physician-performed euthanasia might be acceptable.

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Introduction

Euthanasia is the active ending of another person's life to prevent that person's continued suffering or indignity (sometimes called "active euthanasia"). It is against the law everywhere except in the Netherlands and in Belgium, but is in fact performed not uncommonly by physicians (as well as by family members and other care givers) (Emanuel, Daniels, Fairclough, &

Clarridge, 1998; Meier et al., 1998; Sprung et al., 2003; van der Maas, Pijnenborg, & van Delden, 1995; van der Heide et al., 2003). It is important, therefore, for policy-makers, counselors of ill patients and their families, physicians and other health care providers, medical ethicists, and even judges to understand under what conditions, if any, euthanasia, particularly euthanasia performed by physicians, would be acceptable to lay people and health professionals.

Surveys of public opinion in the US, Canada, and Australia have found that an increasing proportion of people support painless euthanasia of incurably ill patients if they and their families request it from the doctor (Blendon, Szalay, & Knox, 1992; Caddell &

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Newton, 1995; Genuis, Genuis, & Chang, 1994; Rogers, 1996; Singer, Choudhry, Armstrong, Meslin, & Lowry, 1995; Steinberg, Najman, Cartwright, MacDonald, & Williams, 1997; Suarez-Almazor, Belzille, & Bruera, 1997). In the US, this proportion passed from 34% in 1950 to 53% in 1973 and 63% in 1991 (Blendon et al., 1992).

In contrast, fewer members of the medical professions favor euthanasia (Baum & O'Malley 1990; Cohen, Fihn, Boyko, Jonsen, & Wood, 1994; Dickinson, Lancaster, Clark, Ahmedzai, & Noble, 2002; Dickinson, Lancaster, Sumner, & Cohen, 1998; Emanuel et al., 2000; Kitchener, 1998; Kitchener & Jorm, 1999; Kuhse & Singer, 1988, 1992, 1993; Meier et al., 1998; Nilstun, Melltorp, & Hermerén, 2000; Richardson, 1994; Shuman, Fournet, Zelhart, Roland, & Estes, 1992; Suarez-Almazor et al., 1997; Vincent, 1999; Willems, Daniels, van der Wal, van der Maas, & Emanuel, 2000). For example, a survey in 1996 of physicians throughout the US found that, if it were legal, 36% of respondents would be willing to hasten a patient's death by prescribing medication and 24% would provide a lethal injection (Meier et al., 1998).

Physicians in France have been more reluctant than those in the US to advocate interventions by physicians to end patients' lives (Abriven, Chardot, & Fresco, 2000; Glorion, 1999; Michaud, 1999). Nonetheless, even in France, physicians in intensive care units not only withhold or withdraw life-supporting treatments for patients in hopeless conditions (Devictor & Nguyen, 2001; Ferrand, Robert, Ingrand, & Lemaire, 2001) but also occasionally administer drugs with the aim of ending life (Cuttini et al., 2000).

Little is known about the importance and interaction of the various factors that might influence the acceptability of euthanasia. Frileux, Lelièvre, Muñoz Sastre, Mullet, and Sorum (2003) found that, for a hypothetical patient with a life expectancy of only 1 week to 1 month, the patient's age, the level of curability of the illness, the degree of physical suffering despite pain medication, and the extent to which the patient explicitly requested a life-ending procedure had additive effects on lay people's ratings of the acceptability of euthanasia. The patient's mental capacity had no direct effect, but it interacted with request: in the case of no request, acceptability was slightly higher when the patient was mentally impaired. Older participants placed less importance than younger ones on the number of patient requests.

We performed two studies. The first addressed four limitations in the study by Frileux et al. (2003). First, in the 2003 study, the patient was portrayed as able to formulate a request. Since the extent of requesting was the most important determinant of acceptability, we wanted to know what happens when the patient is no longer able to formulate a request—when, for example, the patient is comatose.

Second, we wanted to assess three variables that were not examined in the 2003 study: the patient's life expectancy, the family's attitude toward ending care, and the patient's opinion about organ donation. It has been suggested, but not demonstrated, that the euthanasia is more acceptable when the patient's life expectancy is short than when it is long (Mishara, 1999). Accordingly, a life expectancy of less than 6 months is specifically required for referrals to palliative care through Hospice in the US and for the legal performance of physician-assisted suicide in Oregon (Haley & Lee, 1998; Sullivan, Hedberg, & Fleming, 2000). The family's attitude would be particularly important when the patient is unable to make a request, even when the family is not legally allowed to substitute for the patient in the decision-making process (Meisel, Snyder, & Quill, 2000). Finally, some patients have worried about being prematurely euthanized if they consent to donate their organs; they are aware that organ transplant is more successful when organs are removed before they suffer damage from the dying process (Teisseyre, N., personal conversations with patients, 2002).

Third, whereas Frileux et al. (2003) performed their analyses at the aggregate level, we looked for clusters of participants with quite different ways of responding to the scenarios. We wondered whether some participants would manifest the extreme attitudes frequently encountered in public discussions of end-of-life issues (Curry, Schwartz, Gruman, & Blank, 2000). To allow us to find sufficient people with such attitudes, we gathered a much larger sample of participants than did Frileux and colleagues.

Fourth, we wanted to see if the people's overall judgments of acceptability as well as their cognitive processes—their relative weightings of the different factors in the scenarios and their ways of integrating them when judging acceptability—would be associated with personal characteristics: their values (Cicirelli, 1997), their locus of control (Cicirelli, McLean, & Cox, 2000), and their attitude toward the current laws that prohibit euthanasia.

The aim of our second study was to examine whether health professionals—physicians, nurses, nurse's aides, and health psychologists—would judge the acceptability of euthanasia in the same way as the lay people in the first study.

Methods

The method was an application of the Functional Theory of Cognition (Anderson, 1981, 1996, 2001). The primary aim of Anderson's methodology is to reveal the cognitive rules used by people to integrate information when they make a judgment or decision. It assumes that

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