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Original Article

Public Health Section

Perception and Attitude towards Passive Euthanasia among Doctors in a Tertiary Care Hospital in Northeast India: A Cross-sectional Study

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ABSTRACT

Introduction: The medical fraternity now has more control over the processes of life and death due to advances in medical technology and equipment. Euthanasia has been debated around the world for more than half a century and it continues to raise important questions in medical ethics, moral theology, civil rights and liberty. Physicians' attitudes to life and death emerge to relate their end-of-life decision-making, although usually carried out at the request of ailing person. Physicians' contemplation on euthanasia is a vital building block in the path towards any change, in the euthanasia situation in a country.

Aim: To determine perception and attitude towards passive euthanasia among doctors and to evaluate the association between attitude and variables favourable to passive euthanasia.

Materials and Methods: A cross-sectional survey in the Regional Institute of Medical Sciences (tertiary care hospital), Manipur, India, between October 2018 and September 2020, in Northeast was carried out among 673 doctors. A self-administered questionnaire was designed and approved by three specialists with expertise in palliative care and medical ethics. The questionnaire had a total of 46 questions in English language, of which 15 questions were on socio-demographic profile, 13 were attitude questions and 18 were questions on perception towards passive euthanasia. Attitude questions were scored using 5-point Likert scale from strongly disagree (-2) to strongly agree (+2). Total attitude score ranges from -26 to +26. Score above zero was considered to have positive attitude and vice-versa. There was no scoring to determine perception towards euthanasia. The questionnaires were given to the doctors and postgraduate trainees of clinical and non clinical specialities in a tertiary care hospital in North Eastern India during their work hours. Data were summarised using descriptive statistics. Chi-square test was used to assess factors favouring attitudes toward passive euthanasia.

Results: Age of the respondents ranged from 24 years to 63 years, with a mean age of 37.1±10.7 years and mean duration of experience was eight years. Out of 577 respondents, 368 (63.8%) were postgraduate trainees and 209 (36.2%) were doctors. Majority 463 (80.2%) of the respondents had positive attitude, 97 (16.9%) had negative attitude and 17 (2.9%) had neutral attitude. Total 543 (94.1%) respondents agreed that declaration from patient/family members must be obtained before the act of passive euthanasia. Also, the quality of life as viewed by the patient himself (452, 78.3%) and humanitarian basis (372, 64.4%) were the important factors in influencing decision making regarding passive euthanasia on a terminally ill patient. There was no significant association between sex, age, religion, working category, specialisation, Intensive Care Unit (ICU) experience and attitude towards passive euthanasia.

Conclusion: Majority of the respondents had positive attitude towards passive euthanasia in the face of intractable suffering and terminal illness. Hastened death looks easier to the patients and family because of physical suffering and financial burdens they are subjected to. The doctors got request for euthanasia by the patients and relatives which reflects the public awareness on euthanasia.

Keywords: Legal aspects, Patient preference, Physician decision making

INTRODUCTION

Deliberate and intentional killing of a person for the gain of that person in order to lighten him from pain and suffering is described as euthanasia [1]. Euthanasia can be categorised into two broad types: (a) Active-when a person directly and deliberately does something, which results in the death of patient; (b) Passive-withholding of medical treatment or withdrawal from life support system for continuance of life [2,3]. The medico-technical advances in no way cure the terminally ill patients but prolong their longevity of life with more pain and suffering [4].

Doctors contemplation on euthanasia is an important building block in the path towards bringing about any change in the acceptance of euthanasia. Physicians' attitudes to life and death emerge to relate their end-of-life decision-making, although usually carried out at the request of ailing person. It is important that the doctor's perception and attitude towards passive euthanasia should include social, ethical, legal and medical aspects.

A study done in Oregon reported that majority of doctors were willing to withhold or withdraw treatment which would sustain patient's life [5]. Likewise a study based in New Delhi, India, showed similar findings for seriously ill cancer patients. They consider that patients have the right to decline life-saving curative treatment [6]. Similarly a study in South India in 2010 found that nearly 70% of doctors working in a tertiary care hospital backed the euthanasia concept. Option to euthanise was taken into account because of physical pain and suffering [7]. However, acceptance of euthanasia among Indian doctors was low compared with medical fraternity in United States. This gap shows the difference in social and legal atmospheres in different countries.

Hence, the present exploratory study was conducted at a tertiary care hospital with the objective to determine the perception and attitude towards passive euthanasia among doctors and to document variables favourable to passive euthanasia.

MATERIALS AND METHODS

A cross-sectional survey was conducted among doctors in Regional Institute of Medical Science (RIMS) (tertiary care hospital), Manipur, India, between October 2018 and September 2020. Approval was obtained from the Institutional Ethics Committee before the beginning of study (letter no A/206/REB-Comm(SP)/RIMS/2017/199/67/2018).

Inclusion criteria: All postgraduate medical students (clinical/non clinical) who joined RIMS during the academic years 2016-2017; 2017-2018; 2018-2019 and RIMS doctor employees on payroll which was 673 were included in the study.

Exclusion criteria: Those who could not be contacted even after three consecutive visits and refused to participate were excluded from the study.

Study Procedure

A self-administered questionnaire was designed and was examined and approved by three specialists with expertise in palliative care and medical ethics. The questionnaire had four sections:

Section A: It had 15 questions pertained to the background information and socio-demographic profile of the participants.

Section B: It had 13 statements that recorded the attitude of the participants towards passive euthanasia.

Scoring was given only for the attitude questions. The responses to each statement were scored on a 5-point Likert scale ranging from strongly disagree (-2) to strongly agree (+2). The statements included 11 positively keyed items and 2 negatively keyed items (reverse scoring). Maximum and minimum obtainable score was +26 and -26, respectively. Score above zero was considered to have positive attitude and vice-versa. An overall positive score reflected a positive attitude and overall negative score indicated a negative attitude and score zero for neutral attitude. For the purpose of analysis those with neutral attitude were excluded from the study.

Section C: It had six statements that described what had to be done before the act of passive euthanasia on a terminally ill patient.

Section D: It had 12 questions dealing with the factors influencing decision making in passive euthanasia.

The questionnaires were distributed during the work hours. The filled-in questionnaires were returned to the investigator within a day. Data collected was sorted and checked for completeness and consistency. Confidentiality was maintained.

STATISTICAL ANALYSIS

Data was analysed using International Business Machines Corporation-Statistical Package for the Social Sciences (IBM-SPSS) software version 21.0. Data were summarised using descriptive statistics. Chi-square test was used to assess the association between background characteristics and other variables with attitude. The p-value <0.05 was considered as significant.

RESULTS

Out of 673 participants, 577 were included in the study and 394 (68.3%) were males. Age of the respondents ranged from 24 years to 63 years with a mean of 37.1±10.7 years and mean duration of experience was eight years. Out of total respondents, 368 (63.8%) were postgraduate trainees and 209 (36.2%) were doctors. Of the respondents, 446 (77.3%) felt that physicians should initiate the discussion about passive euthanasia on a terminally ill patient and 59.3% felt that hospital ethics committee need to be consulted when making decisions about passive euthanasia. None of the respondents got any request for passive euthanasia in their practice so far.

From [Table/Fig-1], about half (49%) of the respondents disagreed that withdrawal of life sustaining treatment in passive euthanasia is same as murder. Majority (78.4%) agreed that there should be strict legislation regulating passive euthanasia procedures. Overall

S. No.	Statement	Strongly disagree n (%)	Disagree n (%)	Not sure n (%)	Agree n (%)	Strongly agree n (%)
1	Passive euthanasia is an act of mercy and allows patient who is terminally ill to die with dignity	155 (26.9)	24 (4.2)	30 (5.2)	125 (21.7)	243 (42.1)
2	Regardless of the patients age, disabilities and patients personal preference, a person should be kept alive as long as possible*	261 (45.2)	64 (11.1)	66 (11.4)	99 (17.2)	87 (15.1)
3	Patients with terminal illness should be allowed to die without making heroic efforts to prolong their lives	117 (20.3)	90 (15.6)	114 (19.8)	107 (18.5)	149 (25.8)
4	Withdrawal of life sustaining treatment in passive euthanasia is same as murder*	235 (40.7)	48 (8.3)	53 (9.2)	154 (26.7)	87 (15.1)
5	Doctors have greater authority than patients in decisions about withholding life sustaining treatments	155 (26.9)	76 (13.2)	47 (8.1)	167 (28.9)	132 (22.9)
6	Physicians should comply with a patient's/family request to withhold or withdraw life-sustaining treatment	121 (21.0)	34 (5.9)	22 (3.8)	185 (32.1)	215 (37.3)
7	If necessary, a terminally ill patient should receive drugs to relieve pain and suffering, even if these drugs may hasten the end of the patient's life	73 (12.7)	22 (3.8)	68 (11.8)	240 (41.6)	174 (30.2)
8	The place of dying (e.g., home, hospital etc.,) in case of a terminally ill patient can be decided by the patient or patient party	58 (10.1)	22 (3.8)	4 (0.7)	250 (43.3)	243 (42.1)
9	It is cruel to prolong intense suffering for a person who is mortally ill and desires to die	117 (20.3)	19 (3.3)	103 (17.9)	177 (30.7)	161 (27.9)
10	There should be strict legislation regulating passive euthanasia procedures	89 (15.4)	25 (4.3)	11 (1.9)	211 (36.6)	241 (41.8)
11	Legalisation of passive euthanasia may lead to less aggressive treatment even to patients who can be cured of the disease/suffering	181 (31.4)	111 (19.2)	124 (21.5)	85 (14.7)	76 (13.2)
12	If a terminally ill patient wishes to die, the wish can be honouredethically	144 (25.0)	27 (4.7)	47 (8.1)	88 (15.3)	271 (47.0)
13	If a terminally ill patient wishes to die, the wish can be honouredlegally	142 (24.6)	79 (13.7)	8 (1.4)	159 (27.6)	189 (32.8)

[Table/Fig-1]: Attitude regarding passive euthanasia (N=577).
*negatively keyed items

mean score of all the respondents was 5.63 and the maximum and minimum score obtained were 22.0 and -13.0, respectively.

Of the respondents, 463 (80.2%) had positive attitude, 17 (2.9%) neutral attitude and 97 (16.9%) had negative attitude towards passive euthanasia [Table/Fig-2]. For analysis purpose those with neutral attitude were excluded.

Mean score	Attitude	Score range	Frequency n (%)
<0	Negative attitude	1 to 22	97 (16.9)
0	Neutral	0	17 (2.9)
>0	Positive attitude	-1 to -13	463 (80.2)

[Table/Fig-2]: Mean attitude score of the participants regarding passive euthanasia (N=577).

[Table/Fig-3] shows that 543 (94.1%) respondents agreed that declaration from patient/family members must be obtained before the act of passive euthanasia and 3/4th (75.9%) agreed that withholding and withdrawing treatment in case of passive euthanasia are ethically the same.

S. No.	Statement	Strongly disagree n (%)	Disagree n (%)	Not sure n (%)	Agree n (%)	Strongly agree n(%)
1	Declaration (consent) from patient/family members must be obtained before the act of passive euthanasia	0	0	34 (5.9)	179 (31.0)	364 (63.1)
2	Families should be informed about the advantages and limitations of further therapy and further prognosis	0	0	24 (4.2)	224 (38.8)	329 (57.0)
3	Withholding and withdrawing treatment in case of passive euthanasia are ethically the same	30 (5.2)	23 (4.0)	86 (14.9)	149 (25.8)	289 (50.1)
4	Withholding or withdrawing life support while doing passive euthanasia is unethical	236 (40.9)	86 (14.9)	108 (18.7)	72 (12.5)	75 (13.0)
5	Withholding is more ethical than withdrawing	34 (5.9)	11 (1.9)	320 (55.5)	169 (29.3)	43 (7.5)
6	Withdrawing is more ethical than withholding	114 (19.8)	27 (4.7)	201 (34.8)	182 (31.5)	53 (9.2)

[Table/Fig-3]: What had to be done before the act of passive euthanasia on a terminally ill patient (N=577).

[Table/Fig-4] shows that majority of the respondents felt that quality of life as viewed by the patient and family members were important. Patient unlikely to survive as there are not much alternative treatments and financial costs to patient/family. Also, the quality of life as viewed by the patient himself (452, 78.3%) and humanitarian basis (372, 64.4%) were the important factors in influencing decision making regarding passive euthanasia on a terminally ill patient the important factors in influencing decision making regarding passive euthanasia on a terminally ill patient.

S. No.	Patient factors	Not important n (%)	Less important n (%)	Neutral n (%)	Important n (%)	Very important n (%)
1	Age of the patient	68 (11.8)	16 (2.8)	124 (21.5)	155 (26.9)	214 (37.1)
2	Quality of life as viewed by the patient	81 (14.0)	19 (3.3)	25 (4.3)	317 (54.9)	135 (23.4)
3	Quality of life as viewed by the family	60 (10.4)	14 (2.4)	174 (30.2)	156 (27.0)	173 (30.0)
4	Patient unlikely to survive and there are not much alternative treatments.	63 (10.9)	15 (2.6)	96 (16.6)	217 (37.6)	186 (32.2)
5	At patient/ family members request	64 (11.1)	14 (2.4)	75 (13.0)	131 (22.7)	293 (50.8)
6	Financial costs to patient/family	95 (16.5)	22 (3.8)	76 (13.2)	205 (35.5)	179 (31.0)
Doctor related factors						
7	Personal values and attitude	143 (24.8)	25 (4.3)	137 (23.7)	97 (16.8)	175 (30.3)
8	Humanitarian basis	76 (13.2)	11 (1.9)	118 (20.5)	156 (27.0)	216 (37.4)
9	Religious belief	175 (30.3)	28 (4.9)	126 (21.8)	109 (18.9)	139 (24.1)
10	Knowledge acquired from medical education	134 (23.2)	23 (4.0)	92 (15.9)	134 (23.2)	194 (33.6)
11	ICU bed availability	110 (19.1)	18 (3.1)	93 (16.1)	180 (31.2)	176 (30.5)
12	Litigation or breaking the law	81 (14.0)	13 (2.3)	207 (35.9)	166 (28.8)	110 (19.1)

[Table/Fig-4]: Factors influencing decision making in passive euthanasia (N=577).

[Table/Fig-5] shows that there is no significant association between sex, age, and marital status, religion, working category, specialisation, Intensive Care Unit (ICU) experience and attitude towards passive euthanasia.

Background characteristics	Attitude regarding passive euthanasia		p-value
	Negative n (%)	Positive n (%)	
Sex			
Male	64 (16.0)	316 (83.2)	0.67
Female	33 (18.3)	147 (81.7)	
Age group (years)			
24-40	65 (16.4)	332 (83.6)	0.36
>40-63	32 (19.6)	131 (80.4)	
Marital status			
Single	37 (16.8)	183 (83.2)	0.80
Married	60 (17.6)	280 (82.4)	
Religion			
Hindu	79 (17.6)	371 (82.4)	0.62
Others	23 (20.9)	87 (79.1)	
Working category			
Postgraduates	57 (16.0)	300 (84.0)	0.26
Faculties	40 (19.7)	163 (80.3)	
Specialisation			
Clinical	72 (17.4)	342 (82.6)	0.94
Non clinical	25 (17.1)	121 (82.9)	
ICU experience			
Yes	14 (13.7)	88 (86.3)	0.28
No	83 (18.1)	375 (81.9)	

[Table/Fig-5]: Association between background characteristics with attitude regarding passive euthanasia (N=560)*.
*respondents with neutral attitude (N=17) were excluded from analysis

DISCUSSION

This study showed that the concept of passive euthanasia is acceptable to a large section of doctors (80.2%) in a tertiary care hospital in Manipur, India. This could be due to the fact that, in the contemporary world of diseases like cancer, stroke etc., the

quality of life of the terminally ill patients becomes subsided and to alleviate them of pain and agony, dying seems to to be the logical alternative. No means of complete and curative recovery and the moribund patient himself making the option to end-his-life made these professionals in favour of euthanasia. Furthermore, worldwide acceptance of passive euthanasia may be noted in response to a questionnaire as in the present study, but when the physicians genuinely face such situation in actuality the support may decrease even though it is legalised [8].

A study in New Delhi, India, showed that withholding or withdrawal of treatment was accepted by majority of physicians [6]. Earlier studies from India proclaimed contrasting results [9,10]. However, Hagelin J et al., found that the phrasing of the questions may have affected the results as evidenced from the fact that in this study the questions were pointed towards passive euthanasia specifically [11].

In the current study, more than half of the respondents agreed that patients who are terminally ill should be allowed to die with dignity (63.8%) as compared to Kamath S et al., study (57.1%) [7]. Similarly, 71.8% of the respondents favoured the practice of painkillers such as morphine and palliative sedation to keep the patient comfortable which was similar to Gielen J et al., study [6]. Experience and training of treating terminally ill patients changed their attitude towards euthanasia.

In the study, majority (80.2%) of the respondents had positive attitude regarding passive euthanasia as compared to Kamath S et al., (69.3%) [7]. The most common reason for favouring euthanasia was to curtail physical suffering of a terminally ill patient (63.5%) and there should be strict legislation to perform passive euthanasia on a terminally ill patient (81.7%). Among those who had negative attitude, more than half felt that passive euthanasia could be considered same as murder and that legislation of passive euthanasia may lead to less aggressive treatments when compared to Kamath S et al., (66.2%) and Subba SH et al., (37.4%) [7,12]. The study pointed out that physical suffering and financial burdens were patients' factors that need to be considered while performing passive euthanasia. Likewise, the explanation for not justifying passive euthanasia were allied to ethical and legal dilemmas. These reasons were similar to findings reported by Subba SH et al., [12].

In this study, no association was found between age, sex and being in favour of the concept of passive euthanasia, similar to previous studies [7,13,14]. This may be due to the fact that the knowledge gained by medical curriculum at young adulthood might have influenced their perception towards passive euthanasia and might be unchanged over years. Also, in this study, majority (70.7%) of the respondents were aged 24-40 years and younger generation of Indian doctors might be more open and receptive to the idea of passive euthanasia.

In the study, 70.1% felt that religious belief had no influence on their attitude regarding passive euthanasia whereas in a study by Kamath S et al., (75.9%) had similar opinion [7]. Also, there was no significant association between religion and attitude towards passive euthanasia in contrary to other studies [7,9,15,16]. This could be due to the fact that doctors irrespective of religion, might be of the opinion that, assisting in ending a painful life is performing a good deed and hence fulfilling their moral obligation. On the contrary, studies showed that many Islamic scholars agreed that curative or life sustaining treatment ought not to be forgone [17,18].

In this study, there was no significant association between area of specialisation and attitude towards passive euthanasia in contrary to study done by Emanuel EJ, which found doctors in certain specialties to be more in favour of euthanasia [8]. Studies showed that Geriatricians, Palliative Care specialists, Oncologist were less likely to actively fasten death of a patient [13,19,20]. This may be because of their speciality they are more likely to treat more terminally ill patients in their practice.

This survey focused on passive euthanasia in all dimensions compared to other surveys in India, which did not make a clear distinction between active and passive euthanasia. The study respondents were doctors from various specialties who were directly or indirectly related to decision making about euthanasia which adds an edge over other studies.

Limitation(s)

One of the key limitations is that, since this study relied on self-reported responses, there was no objective way to know whether the perception of passive euthanasia remains unchanged when they actually face the situation in reality. The study did not explore other areas of relevance such as patients' and family members' perceptions. In addition, the study was done among doctors from one institution only and this somewhat restricts the generalisation of the results to the whole doctor population in India.

CONCLUSION(S)

Majority of the doctors had positive attitude towards passive euthanasia. Sex, age, marital status, religion, area of specialisation and ICU experience did not influence their attitude towards passive euthanasia. Opinion of larger representative population about passive euthanasia will be needed in order to understand better the concept, because of the increasing number of patients subjected to palliative care and life sustaining treatments.

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