



Chapter 6

Can physicians conceive of performing euthanasia in case of psychiatric disease, dementia or being tired of living?

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ABSTRACT

Background

Euthanasia and physician-assisted suicide (EAS) in patients with psychiatric disease, dementia or patients who are tired of living (without severe morbidity) is highly controversial. Although such cases can fall under the Dutch Euthanasia Act, Dutch physicians seem reluctant to perform EAS, and it is not clear whether or not physicians reject the possibility of EAS in these cases altogether.

Aim

To determine whether physicians can conceive of granting requests for EAS in patients with cancer or another physical disease, psychiatric disease, dementia or patients who are tired of living, and to evaluate whether physician characteristics are associated with conceivability. A cross-sectional study (survey) was conducted among 2269 Dutch general practitioners, elderly care physicians and clinical specialists.

Results

The response rate was 64% (n=1456). Most physicians found it conceivable that they would grant a request for EAS in a patient with cancer or another physical disease, (85% and 82%). Less than half of the physicians found this conceivable in patients with psychiatric disease (34%), early-stage dementia (40%), advanced dementia (29-33%) or tired of living (27%). General practitioners were most likely to find it conceivable that they would perform EAS.

Conclusions

This study shows that a minority of Dutch physicians finds it conceivable that they would grant a request for EAS from a patient with psychiatric disease, dementia or a patient who is tired of living. For physicians who find EAS inconceivable in these cases, legal arguments and personal moral objections both probably play a role.

6.1 INTRODUCTION

One of the most difficult requests a physician can receive, is that for euthanasia or physician-assisted suicide (EAS). Each request requires careful deliberation by the physician, a process that can have a considerable emotional impact.(1) In countries where euthanasia or assisted dying is permissible under certain circumstances (the Netherlands, Belgium, Luxembourg, Switzerland and four US states), physicians grant or refuse such requests based on personal ethical and psychological arguments, while taking the legal boundaries into account. Physicians are always free to refuse a request for EAS; patients do not have a 'right to euthanasia'. However, this 'freedom to refuse' has become topic of societal debate in the Netherlands. The popular media have reported on patients whose requests for EAS seem to have been refused on the basis of the physicians' personal opposition instead of legal objections, and the media have questioned these decisions.(2, 3) These patients had psychiatric disease, dementia or were 'tired of living' (in the absence of severe disease). The main question debated is whether EAS is legally and ethically acceptable in patients with these conditions and, if so, whether physicians should be willing to provide it.(2-5)

EAS is defined as the act of administering lethal drugs to a patient (euthanasia) or providing a patient with lethal drugs (physician-assisted suicide) by a physician with the intention of ending his or her life, on the patient's explicit request, resulting in the death of the patient. In the Netherlands, most requests for EAS are from patients with cancer (72%) or another physical disease (19%). A minority of requests are from patients who have dementia (4%), are tired of living in the absence of severe disease (3%), or have a psychiatric disease (2%).(6) The Dutch legal framework for EAS is defined in the Termination of Life on Request and Assisted Suicide (Review Procedures) Act (2002), and is further specified by jurisdiction. The Act lays down official criteria for due care, which a physician must meet to be exempted from prosecution. The criteria are: (1) the presence of unbearable suffering without prospect of improvement, (2) a voluntary and well-considered request for EAS from the patient, (3) a patient who is informed about the situation and prognosis, (4) absence of reasonable treatment alternatives, (5) the consultation of a second physician and (6) EAS is performed with due medical care and attention.(7)

No restrictions are mentioned relating to cause of suffering in the act. Physicians are obliged to report each case to a Regional Review Committee, who afterwards decide whether the criteria for due care were met.

Over the past few decades, some cases of EAS in patients who had psychiatric disease, dementia or were tired of living (in the absence of severe disease) were

reported. The Regional Review Committees deemed that the criteria for due care can be met in these cases, but only if the patient's suffering is predominantly caused by a medical condition.(8-12) Moreover, the committees warn that in these cases special care must be taken since it can be difficult for physicians to assess whether the due care criteria have been met.(12, 13) The legal issues and the prevalence of these cases are described in box 1.

Box 1: Overview of legal issues and prevalence of euthanasia and physician-assisted suicide (EAS) in the Netherlands in patients with psychiatric disease, dementia and patients who are tired of living

Psychiatric disease

The Regional Review Committees call for extra attention in assessing whether a request for EAS by a patient with a psychiatric disease is voluntary and well-considered. However, if the decisional competence of a patient is not affected and all other due care criteria have been met, EAS is permissible. (10) The number of reported cases in the Netherlands increased from none in 2009 to 14 in 2012. All cases were approved by the Review Committees.(10-13)

Dementia

EAS in early-stage and advanced dementia can fall under the Dutch legislation. The Regional Review Committees have stated that patients with early-stage dementia can suffer unbearably from the prospect of progressive dementia, and therefore the due care criteria can be met.(12) In advanced dementia, when a patient is no longer able to express his or her wishes, a previously written advance euthanasia directive can, in some cases, replace an oral request.(13) The number of reported cases of EAS in patients with dementia in the Netherlands increased from 12 cases in 2009 to 42 in 2012 (1% of all EAS cases). (10-13) In almost all cases, the patients had early-stage dementia and were competent. However, at least one case of a patient with advanced-stage dementia is described and was approved by the Review Committees.(13)

Being tired of living

Being tired of living is defined as suffering caused by the prospect of having to continue living with a very poor quality of life, not predominantly caused by a physical or psychiatric disease, leading to a persistent death wish.(17) Jurisprudence in 1994 states that a patient who is tired of living can suffer unbearably, if the patient experiences it as such.(8) However, jurisprudence in 2002 adds that, in order for a physician to be able to assess the extent of suffering, the main cause of suffering must be medical. (9) Recently, the Royal Dutch Medical Association (KNMG) published a position paper stating that there must be medical grounds for suffering, but these medical grounds need not necessarily be the main cause of suffering.(18) Although there were some cases of EAS that have been reported (and approved) in patients who suffered unbearably from an accumulation of factors or conditions, no cases in which suffering was not predominantly caused by medical grounds have been reported.(2)

While the Regional Review Committees do not necessarily disapprove, a recent vignette study showed that 18-35% of Dutch physicians approve of EAS in cases where patients have severe depression, early-stage dementia, advanced dementia or are tired of living, compared to 77% in case of a patient suffering from incurable cancer.(5) An earlier vignette study asked physicians whether the physician would

be willing to perform EAS in different scenarios. While 64% were willing to perform EAS in a patient with advanced cancer, only 6-11% were willing to do so in a patient with advanced dementia or in the absence of severe disease. (14) As far as we know, there are no other studies on the relationship between cause of suffering and physicians' willingness to perform EAS. (15, 16)

Although the literature shows that there is a relationship between cause of suffering and attitude towards EAS, it is not known whether the cause of suffering in itself is a decisive factor for physicians when assessing a request for EAS. Therefore, the aim of this study is to describe whether physicians can conceive of granting a request for EAS (or have granted requests for EAS) in patients with cancer or another physical disease, psychiatric disease, dementia or who are tired of living (in the absence of severe disease). Furthermore, we aim to identify physician characteristics that influence conceivability.

6.2 METHODS

Design and population

We conducted a cross-sectional survey among physicians providing care for patients living at home or in residential homes (general practitioners; GPs), patients in nursing homes (elderly care physicians; ECPs) and patients receiving hospital-based care (clinical specialists). A questionnaire was mailed to a random sample of 1100 GPs, 400 ECPs and 1000 clinical specialists (250 internists, 150 cardiologists, 150 intensivists, 150 neurologists, 150 pulmonologists and 150 surgeons). These groups of physicians were chosen because they are involved in most deaths. Addresses were obtained from a national databank of registered physicians (Bohn Stafleu-van Loghum medical databank). Inclusion criteria were: (1) working as a physician in patient care in the current specialty for the last year; (2) working in the Netherlands; and (3) having a registered work address.

Ethics approval

The study did not require review by an ethics committee under Dutch law.

Data collection

The questionnaire was similar to one used in a large scale study in 2005 and a study in 2001, 1995 and 1990.(19) A validation study of the similar questionnaire was carried out in 2005 and the new questionnaire was piloted with 12 physicians. The complete (Dutch) questionnaire has been previously published.(6) Anonymity

was guaranteed by the use of unnumbered anonymous questionnaires. Data were collected from October 2011 to June 2012. During this time, two reminders were sent which contained a link to an on-line version of the questionnaire. In the questionnaire, physicians were asked whether they had ever performed EAS in patients suffering from the following causes; cancer, another physical disease, a psychiatric disease, early-stage dementia, advanced dementia (on the basis of an advance euthanasia directive), advanced dementia without severe comorbidities (on the basis of an advance euthanasia directive), being tired of living without a serious physical or psychiatric disease, and being tired of living without any medical grounds for suffering. If a physician stated they had never performed EAS in a specific category, they were asked whether they found it conceivable that they would do so. For analysis, physicians who had performed EAS were considered to find it conceivable. No distinction was made between euthanasia and physician-assisted suicide, because we were interested in the physician's decision whether or not to help a patient who wished to die, and not in the decision on which method to use. Moreover, the criteria for due care do not differentiate between physician-assisted suicide and euthanasia.

The questionnaire included a section on respondent characteristics. Respondents were asked about their age, gender, whether they were religious and, if so, which religion they adhered to. Furthermore, they were asked how long they had been working in their specialty, whether they had received training in palliative care (not including regular curricular training) or work as palliative care consultant or SCEN physician (a physician who is specially trained in providing consultation or advise on EAS to physicians), and how many patients had died under their care in the last year.

Statistical analysis

Data analysis was carried out using IBM SPSS Statistics software, version 20.0. For each specialty, a weight factor was calculated in order to make the sample representative of all physicians in the Netherlands working in the described specialties.⁽⁶⁾ Multivariate analysis was carried out to study whether conceivability of performing EAS correlated with age, years of working experience, gender, being religious, number of patient deaths in the last year, having received training in palliative care, being a palliative care consultant and being a SCEN physician. Stepwise backward multiple regression (removal at $p < 0.05$) was performed and ORs with 95% CI were calculated. Missing answers were excluded from analysis.

6.3 RESULTS

Characteristics of respondents

Of 2500 sampled physicians, 2269 were eligible. A total of 1456 physicians responded (64%), with 27 using the on-line version. The respondents were 708 GPs (response rate 72%), 287 ECPs (response rate 80%) and 461 clinical specialists (56 cardiologists, 70 surgeons, 75 intensivists, 105 internists, 71 pulmonologists, 78 neurologists, 6 specialty unknown; response rate 49%). Some non-responders (269 of 813) sent in a response card stating the reasons for non-response. The main reasons were lack of time (n=161), no experience with (requests for) euthanasia (n=53) and feeling overloaded by requests to participate in research (n=10).

Table 1 shows the characteristics of the respondents. Mean age was 50 years (range 30-72), 63% were male, 55% had received training in palliative care, 3% were palliative care consultant and 5% were SCEN physicians.

In total, 77% (95% CI 75% to 80%) of physicians had received one or more requests for EAS during their career: 93% of GPs, 71% of ECPs and 53% of clinical specialists. Half of the ECPs (52%) had cared for a patient with advanced dementia who had a written advance euthanasia directive stating they requested euthanasia in case of advanced dementia (data not shown).

Cause of suffering and conceivability of performing EAS

Table 2 shows that most responding physicians found it conceivable that they would perform EAS (86%, 95% CI 84% to 88%). Furthermore, 60% had ever performed EAS (95% CI 58% to 63%) and 28% had done so in the last year (95% CI 26% to 31%). A minority (14%, 95% CI 13% to 16%) found it inconceivable that they would perform EAS.

The results are also shown for each cause of suffering separately in table 2. In case of a patient with cancer, 85% found it conceivable that they would perform EAS (95% CI 83% to 87%) and 56% had ever done so. In case of a patient with another physical disease, 82% found it conceivable (95% CI 80% to 84%) and 31% had ever done so. Physicians were significantly less likely to find EAS conceivable in all other causes of suffering, such as psychiatric disease (34%, 95% CI 31% to 37%). The proportion of physicians who found it conceivable that they would perform EAS was significantly higher in case of early-stage dementia (40%, 95% CI 38% to 43%) than in case of advanced dementia with comorbidities (33%, 95% CI 31% to 36%) or without comorbidities (29%, 95% CI 27% to 32%). In patients who are tired of living without severe disease, 27% (95% CI 25% to 30%) found it conceivable that they would grant a request for EAS, compared to 18% if there are no medical grounds for suffering (95% CI 16% to 20%; a significant difference). A small minority of physicians had ever performed EAS in a patient suffering from causes other than cancer or another severe physical disease (7%, 95% CI 6% to 9%).

Table 1. Background characteristics of respondents

	GPs (n=708) %	ECPs (n=287) %	Clinical specialists* (n=461) %	Total* (n=1456) %
Age, years[†]				
Mean ± SD	50±8	50±8	50±9	50±8
(range)	(31-72)	(30-68)	(33-67)	(30-72)
Gender[†]				
Male	61	41	72	63
Female	39	59	28	36
Being religious^{†‡}				
Yes	37	44	36	37
Years of working experience (in their specialty)[§]				
Mean ± SD	19±9	17±9	16±9	18±9
(range)	(1-42)	(1-39)	(1-38)	(1-42)
Received training in palliative care[†]				
Yes	73	72	23	55
Palliative care consultant[†]				
Yes	2	6	4	3
SCEN physician^{†¶}				
Yes	6	5	2	5
Number of deceased patients in the last year[§]				
None	1	0	3	1
1-9	38	15	25	32
10-19	36	40	32	35
>19	26	45	41	32

* Weighted percentages.

† Missing values range from 0.5% to 1.6%.

‡ According to the respondent; Christian religion in 93% of cases.

§ Missing values range from 9.5% to 22.3%.

|| Not including regular curricular training.

¶ A SCEN physician is a trained physician from whom other physicians can obtain information and advise about EAS, or request a formal consultation (one of the criteria for due care).

EAS, euthanasia and physician-assisted suicide; ECPs; elderly care physicians; GPs, general practitioners.

Table 2 Experience with and conceivability of performing EAS according to cause of suffering, all responding physicians*†

	Has performed EAS	Conceivable that they would perform EAS (including physicians who ever performed EAS)	Inconceivable that they would perform EAS
	% (95% CI)	% (95% CI)	% (95% CI)
EAS in general	60 (58 to 63)	86 (84 to 88)	14 (13 to 16)
According to cause of suffering:			
Cancer	56 (53 to 58)	85 (83 to 87)	15 (13 to 17)
Another physical disease	31 (29 to 34)	82 (80 to 84)	18 (16 to 20)
A psychiatric disease	2 (2 to 3)	34 (31 to 37)	66 (63 to 69)
Early-stage dementia, in a competent person	3 (2 to 4)	40 (38 to 43)	60 (57 to 62)
Advanced dementia, on the basis of a written AED‡	0.8 (0.5 to 1.5)	33 (31 to 36)	67 (64 to 69)
Advanced dementia, on the basis of a written AED‡, in the absence of severe comorbidities	0.5 (0.2 to 1.0)	29 (27 to 32)	71 (68 to 73)
Being tired of living, with medical grounds for suffering but in the absence of a severe physical or psychiatric disease	3 (2 to 4)	27 (25 to 30)	73 (70 to 75)
Being tired of living, without medical grounds for suffering	2 (2 to 3)	18 (16 to 20)	82 (80 to 84)

* Weighted percentages.

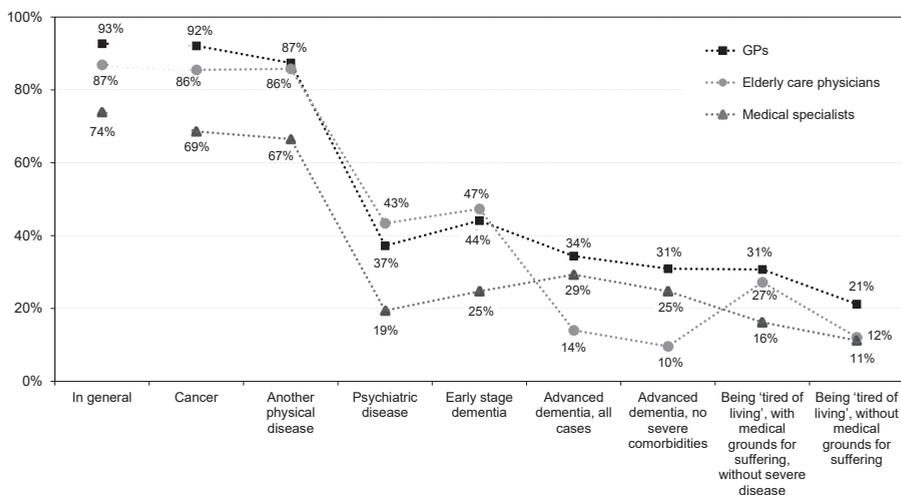
† Missing values range from 0.8% to 9.8%.

‡ AED, advance euthanasia directive; EAS, euthanasia and physician-assisted suicide

Physician specialty and conceivability of performing EAS

The different physician specialties are compared in figure 1. GPs most often found it conceivable that they would perform EAS (93%, 95% CI 91% to 94%) and had most often performed EAS (79%, 95% CI 76% to 82%; not shown in figure). Of ECPs 87% (95% CI 82% to 90%) found it conceivable and 37% (95% CI 33% to 44%) had ever performed EAS. Of clinical specialists 74% found it conceivable that they would perform EAS (95% CI 70% to 78%, percentage ranging from 61% in cardiologists to 83% in intensivists) and 34% had ever done so (95% CI 30% to 38%, ranging from 17% in intensivists to 54% in pulmonologists). For each cause of suffering, GPs were significantly more likely than other physicians to have performed EAS (data not shown). The percentage of physicians who could conceive of performing EAS was highest among GPs and ECPs and lowest among clinical specialists in most causes of suffering except for advanced dementia (lowest among ECPs).

Figure 1: The percentage of physicians who found it conceivable that they would perform euthanasia or physician-assisted suicide (EAS) in patients suffering from different causes, according to physician specialty.



For all causes of suffering, there were significant differences between the physician specialties (χ^2 test, $p < 0.05$). Missing values range from 1.8% to 11.3%. AED, advance euthanasia directive; GP, general practitioner.

Physician characteristics and conceivability of performing EAS

Table 3 shows which physician characteristics were associated with the conceivability of performing EAS, identified by logistic regression analysis. First, there were significant differences between the physician specialties regarding each cause of suffering. Compared to clinical specialists, GPs were more likely to find it conceivable that they would perform EAS in general (OR 5.3, 95% CI 3.6 to 7.7) and in each cause of suffering separately (OR 1.6-6.3). ECPs were also more likely than clinical specialists to find it conceivable that they would perform EAS in general (OR 3.0, 95% CI 2.0 to 4.7), and in most causes of suffering separately. However, in case of advanced dementia, ECPs were significantly less likely to find it conceivable that they would perform euthanasia than clinical specialists (OR 0.41-0.51) and GPs (OR 0.25-0.33).

Two other factors that influenced conceivability in all causes of suffering were identified: being religious (OR 0.18) and being a SCEN physician (OR 10.6). Age, being a palliative care consultant and number of patient deaths in the last year were not related to the probability of finding performing EAS conceivable. Other variables were correlated with conceivability only in some causes of suffering.

Table 3. Correlation between physician characteristics and conceivability of performing EAS*

	Physician specialty:		Female sex	Religious	Years of working experience [§]	Have received training in palliative care	SCEN physician
	GP	ECP					
EAS in general	5.3 (3.6 to 7.7)	3.0 (2.0 to 4.7)	-	0.18 (0.13 to 0.26)	-	-	10.6 (1.2 to 95.1)
According to cause of suffering:							
Cancer	6.3 (4.3 to 9.2)	3.6 (2.3 to 5.6)	1 to	0.17 (0.12 to 0.24)	-	-	11.5 (1.3 to 103.9)
Another physical disease	4.7 (3.3 to 6.6)	3.8 (2.5 to 5.8)	1 -	0.19 (0.14 to 0.27)	-	-	14.4 (1.6 to 129.3)
Psychiatric disease	2.6 (1.9 to 3.4)	3.3 (2.3 to 4.7)	1 -	0.58 (0.45 to 0.74)	-	-	6.1 (3.3 to 11.4)
Early-stage dementia	2.4 (1.8 to 3.2)	2.7 (1.9 to 3.9)	1 -	0.50 (0.39 to 0.65)	0.98 (0.97 to 0.99)	-	10.1 (4.6 to 22.0)
Advanced dementia	1.6 (1.2 to 2.1)	0.51 (0.33 to 0.78)	1 0.71 (0.55 to 0.92)	0.66 (0.52 to 0.86)	-	0.72 (0.55 to 0.95)	2.2 (1.3 to 3.7)
Advanced dementia, without other disease	1.7 (1.2 to 2.3)	0.41 (0.26 to 0.67)	1 0.69 (0.52 to 0.90)	0.56 (0.43 to 0.74)	-	0.74 (0.56 to 0.99)	2.0 (1.1 to 3.4)
Tired of living, with medical grounds for suffering	2.4 (1.8 to 3.3)	2.0 (1.4 to 3.0)	1 -	0.58 (0.44 to 0.75)	-	-	6.2 (3.5 to 11.0)
Tired of living, without medical grounds for suffering	2.2 (1.5 to 3.1)	1.1 (0.68 to 1.7)	1 -	0.54 (0.39 to 0.74)	-	-	2.3 (1.5 to 3.1)

*Separate logistic regression models were fitted for each situation. Odd ratios (with 95% CI) are presented in the table when significantly different (p≤0.05) from the null value.

† Age, number of deceased patients in the last year (categorised in three groups) and being a palliative care consultant were also entered into the logistic regression, but for none of the causes of suffering was a significant relationship with conceivability found.

‡ Reference group for the physician groups.

§ Linear association, OR is presented per year of working experience.
- indicates the item was entered in the regression but was not significant and consequently eliminated in the stepwise procedure.
EAS, euthanasia and physician-assisted suicide; ECP, elderly care physician; GP, general practitioner.



6.4 DISCUSSION

Our findings show that for most physicians the cause of suffering can be a decisive factor in deciding on requests for EAS. While the majority finds it conceivable that they would perform EAS in patients with cancer or another physical disease, approximately one in three physicians find it conceivable in patients suffering from other causes. These findings are in line with previous studies in which physicians were found to be more accepting of EAS in case of physical suffering than in case of non-physical suffering. (5, 14, 20)

Conceivability depends on cause of suffering

Factors that could explain why most physicians find EAS inconceivable in patients with psychiatric disease, dementia or patients who are tired of living seem to partly overlap with the criteria for due care. One of these factors is doubt about whether suffering is unbearable in these cases. Van Tol described that physicians are less likely to label suffering as unbearable and to be willing to perform EAS in psychosocial suffering compared to physical suffering.(20) Because suffering in early-stage dementia or being tired of living is predominately psychosocial or existential (and related to, for example, perceived dependency, fear of future decay and loss of dignity) rather than physical, physicians might not consider it as unbearable.

In case of advanced dementia, many physicians point out that it is impossible to determine whether a patient is suffering unbearably, due to a lack of meaningful communication.(6, 21) Moral objections, not related to the criteria for due care, also play a role in advanced dementia. Many ECPs state that it is impossible to determine at what moment an advance euthanasia directive is to be carried out, if the patient can no longer specify this.(6, 21) Also, it is probable that physicians cannot conceive of performing euthanasia in a patient with dementia who might not fully comprehend what is happening. Our study suggests that, in actual practice, physicians would rarely act upon an advance euthanasia directive in case of advanced dementia. People who write such directives are often unaware of this.(22)

Little is known about physicians' opinions on EAS in psychiatric patients. One study from 1997 among psychiatrists showed that the main reasons for refusing EAS in psychiatric patients were doubts about whether all treatment options had been exhausted and whether the suffering was unbearable and hopeless.(23) Furthermore, before 2012 physicians did not, or very rarely, heard about cases of EAS in psychiatric patients. Therefore 'cold feet' of physicians could also have contributed to their

reluctance.(2) A similar explanation could hold true for dementia and being tired of living.

A physician can base their decision on legal and on personal arguments

We noted that some possible reasons for physicians' reluctance to perform EAS overlap with the criteria for due care. One could question whether physicians are even aware that the criteria can be met in case of psychiatric disease, dementia or being tired of living. However, 15 to 59% (depending on cause of suffering) of the 67 SCEN physicians in our sample found it inconceivable that they would perform EAS in such cases (while 99% of them found it conceivable that they would perform EAS in case of cancer or another physical disease). As these physicians receive training in the criteria for due care, it is unlikely that lack of knowledge plays a role. Therefore, inconceivability among SCEN physicians is most likely based on moral objections, and these moral objections would probably play a role for other physicians as well.

Some argue that refusal of requests for EAS which would be legally possible is an undesirable situation, in which patients are dependent on their physicians' personal views. On the other hand, the 'freedom to refuse' is highly valued by Dutch physicians. Because performing EAS can have a serious emotional impact on a physician,(1) they should only perform EAS if they can fully support this action in the particular patient and have no insurmountable moral objections. If a physician is not willing to perform EAS although the criteria for due care can be met and normal palliative care does not suffice, the physician can refer the patient to a colleague who might be willing to perform EAS.

Conceivability is associated with specialty and other physician characteristics

GPs more often found it conceivable that they would perform EAS than other physicians. This could be a consequence of the long-term relationships GPs have with their patients, which might allow them to better identify with the patient, to judge their suffering, and be considered the preferred physician to perform EAS.

Interestingly, conceivability to perform euthanasia in case of advanced dementia was lowest among the physicians who are most frequently involved in the care of these patients, the ECPs. This reluctance could be due to their experience with and knowledge about the complexity of this specific situation.

Being a palliative care consultant and having received training in palliative care were not associated with conceivability. Contrary to what some might expect, a high level of knowledge about palliative care does not seem to influence attitude towards

performing EAS. SCEN physicians more often found it conceivable that they would perform EAS than other physicians. SCEN physicians are familiar with the legal boundaries, have affinity with EAS, and their experience as consultants might have influenced their standpoint on EAS. In line with previous findings,^(15, 16) we found that religious physicians (93% Christian) were less likely to find it conceivable that they would perform EAS than non-religious physicians. These physicians probably reject EAS on the basis of religious principles, such as the sanctity of life argument. (24)

Strengths and limitations

The most important strengths of this study are the nationwide sample of physicians working in different specialties and the substantial response rate (64%). In contrast to most other studies, we asked physicians what their own actions might be instead of asking about acceptability in general, and we focussed solely on cause of suffering as the determining factor. Furthermore, because anonymity was guaranteed, physicians were less likely to give socially acceptable answers.

A possible limitation is selection bias. The response rate was somewhat low for clinical specialists (49%). Although the results were made representative by the use of weight factors, non-responders might differ from responders in their views on EAS. This could have resulted in an overestimation of conceivability of performing EAS. (25) Second, our study did not include psychiatrists, although they treat most patients with severe psychiatric disease. In a 1997 study, 46% of psychiatrists were willing to assist in suicide under certain circumstances.⁽²³⁾ In our study, 34% of all physicians could conceive of performing EAS in psychiatric disease. Third, interpretation of the concept 'conceivable' might have caused some confusion. Clinical specialists who are not responsible for the care of certain patients (for instance, an asthma specialist does not treat a patient for cancer) might therefore not consider it conceivable that they would perform EAS in these patients. For GPs and ECPs, who may be involved in all of the discussed cases, interpretation will not have been a problem.

6.5 CONCLUSION

In conclusion, most Dutch physicians can conceive of performing EAS in patients suffering from cancer or another physical disease. However, in patients suffering from psychiatric disease, dementia or being tired of living, opinions differ. To prevent disagreement and disappointment, it is important that a patient with a future

wish for EAS discusses this with their physician in time and that the physician is clear about his or their standpoint on the matter.

DECLARATIONS

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Competing interests

None.

Provenance and peer review

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