Acceptance of euthanasia and the factors influencing it

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1. Background

The end of life is, in developed countries, increasingly typified by chronic illnesses with protracted dying trajectories and increasing possibilities to prolong life and manage the diverse illness-associated problems. This has also entailed that decisions potentially influencing patients’ life span (Bilsen et al. 2009; Chambaere et al. 2011; Chambaere et al. 2015) become a pertinent part of end-of-life medical practice. Physicians may decide to withhold or withdraw life-prolonging treatment or to carry out intensified symptom treatment or continuous sedation, and patients may stop eating and drinking. In some cases, however, physicians are confronted with patient requests for assisted dying, which can take the form of assistance in suicide or euthanasia.

It seems clear that the acceptance of assisted dying in developed countries is growing, judging by the increasing legislative debate worldwide (Cohen-Almagor 2013; Materstvedt 2003), trends in actual practice (Bilsen et al. 2009; Chambaere et al. 2011; Chambaere et al. 2015; Chambaere et al. 2010; Cohen et al. 2010), as well as public opinion polls (Cohen et al. 2006a; Cohen et al. 2006b; Cohen et al. 2013; Cohen et al. 2014). This article deals with three key points related to this acceptance of assisted dying:

1. Legislation around assisted dying is increasingly debated with regulation of assisted dying occurring in an increasing number of countries and states.
2. In countries with a law on assisted dying (or euthanasia) – and I will particularly focus on Belgium – there seems to be an increased acceptance of the practice by patients but also by physicians, which results in an increasing frequency of the practice.
3. Acceptance of assisted dying within a society is strongly related to various cultural and sociodemographic factors, including levels of religiousness, tolerance towards autonomy in life choices, and trust.
2. Legislation around assisted dying

The current situation is that euthanasia has been legalized in five countries: The Netherlands (2002), Belgium (2002), Luxembourg (2009), Canada (2015), and Colombia (2015); physician assisted suicide is legalized or legally practiced in one country (Switzerland) and five US-states (Oregon, Washington, Montana, Vermont, California) (Figure 1).

Figure 1: Regulation of assisted dying (euthanasia or physician assisted dying around the world)

Europe  USA

Canada  South America

For a reference: see Dyer et al. 2015.

The Netherlands was the first country to adopt a law on euthanasia in April 2002 after about thirty years of experience with the practice and regulated tolerance between 1990 and 2002 (Deliens/van der Wal 2003). The law also includes physician assisted suicide. The Belgian law, adopted by parliament in May 2002, was strongly based on the Dutch law (Deliens/van der Wal 2003). Although it does not mention physician assisted suicide the practice is considered to be a form of euthanasia by the eutha-
nasia review committee (Euthanasia FCaECo). Luxembourg followed with a law in March 2009, largely based on the Belgian law and also includes physician assisted suicide (Watson 2009). Switzerland has a non-prosecution of assistance in suicide based on a law from 1942 promulgating that only assistance in suicide out of selfish motives can be prosecuted (Bosshard 2012). From the 1980s onwards the law was interpreted by several right-to-die movements across the countries as a legal permission to set up organizations administering life-ending drugs. Oregon was the first US state to enact a law regulating physicians assisted suicide in October 1997 (Coombs 2014). Washington (since 2009) and Vermont (in 2013) followed Oregon in enacting a law on physician assisted dying with a protocol for practice (Dyer et al. 2015). In Montana, a court ruling in 2009 and the ensuing jurisprudence decriminalized the practice. A similar court ruling occurred in New Mexico in 2014, but it was reversed on appeal in August 2015. California became the latest US state to legally regulate the practice in September 2015. In several other states legalization is under consideration (Orentlicher et al. 2014). In Canada, Quebec province legalized physician assisted suicide and euthanasia in June 2014 (Dyer 2015). As of February 2015 assisted suicide and euthanasia are also legal in the whole of Canada as a result of the ruling of the Supreme Court of Canada in the Carter versus Canada case, pending a twelve-month period of suspension. The court ruling implies that a law regulating the practice needs to be in place by February 2016 (Attaran 2015). In Colombia, the government issued a regulation for euthanasia in April 2015. The legalization of assisted dying is being discussed in several other countries as well (Delamothe et al. 2014) and it is likely that the number of countries adapting a law will increase in the coming decade.

Although some countries have legally accepted both euthanasia and physician assisted suicide, some countries or states have chosen to only regulate physician assisted suicide. Although both forms of assisted dying are very similar, there are important differences. Euthanasia is the act where a physician administers drugs to end the patients' life at the explicit request of the patient. Physician assisted suicide is the act where a physician prescribes drugs to end the patients' life at the explicit request of the patient but the patient takes these drugs him- or herself (Chambaere et al. 2011; van der Heide et al. 2003).

The existing laws stipulate several strict substantive criteria for the practice to be considered legal (Smets et al. 2009). In the countries that have a euthanasia law (Belgium, The Netherlands, and Luxembourg – in
Canada no law is written yet at this point) these substantive criteria regard the request of the patient (has to be explicit, voluntary, well considered, repeated and not the result of external pressure), the nature of suffering (has to be unbearable and irreversible and cannot be alleviated; the suffering can be physical or psychological but has to result from a medical condition or disease), the prospect of improvement (there is no reasonable prospect of improvement) and the information provided to the patient (the physician has informed the patient about his or her situation and prospects). Next to the substantive criteria there are procedural criteria, both \textit{a priori} (the attending physician must consult another independent physician before deciding to grant a request) and \textit{a posteriori} (the physician must notify the case of euthanasia for review).

3. \textit{Trends in the practice of assisted dying in Belgium}

A recent publication in the New England Journal of Medicine (Chambaere et al. 2015) provides insights into the most recent trends in euthanasia and other end-of-life decision making in Belgium. It provides data based on a series of population-based and nationwide (Flanders, Belgium) studies in large representative samples of deaths (as identified through death certificate data). Attending physicians of those deaths were asked to fill out questionnaires concerning the end-of-life decision-making in the corresponding patient. A procedure involving a lawyer as a trusted third party provided complete anonymity for the physicians (and the deceased patients). Details about the methods of these studies can be found elsewhere (Chambaere et al. 2011; Chambaere et al. 2015; Chambaere et al. 2010; Cohen et al. 2010; Chambaere et al. 2008).

A first survey wave was held during 1998, four years prior to the legalization of euthanasia; a second was held during the legalization process in 2001; a third in 2007, five years after legalization; and the fourth in 2013. In this latest survey a total of 6871 deaths were sampled. A net response rate of 61 percent was received for these deaths. Using indirect operationalizations of euthanasia enabled reliable estimations regarding the frequency of euthanasia: i. e. not by directly asking about euthanasia but by asking whether the physician administered, supplied or prescribed drugs with the explicit intention of hastening death. If in the latter case the drugs had been administered at the patient’s explicit request, the act was classified as euthanasia (or assisted suicide depending on whether the patient...
self-administered the drugs). If drugs were used with the same explicit intention to hasten death but without the patient’s explicit request, the act was classified as hastening death without explicit patient request. This can include cases where a patient’s request was not judged as explicit by the physician, where the request came from the family or where the physician acted out of compassion.

The findings show that the frequency of euthanasia increased from 1% of all deaths in 1998 (prior to the legalization of euthanasia) over about 2% in 2007 (five years after the legalization), to more than double six years after, 4.6% of all deaths in 2013. After a decrease from 3.2% in 1998 to 1.8% in 2007, the rate of hastening death without an explicit request from the patient remained stable at 1.7% in 2013. With the 4.6% incidence of euthanasia in Flanders, Belgium’s frequency is now, for the first time, higher than in The Netherlands where a study using the same methods in 2010 found an incidence rate of 2.8%, which was an increase compared with the incidence rate found in the country in 2005 (1.7%), but comparable to the rate found in 2001 (prior to legalization in 2002, but during a period of regulated tolerance) (Onwuteaka-Philipsen 2012).

If we were to further explore the reasons behind the strong increase, we could link the increase to two highly significant trends:

First, we observed that the number of people who died and who had made a request for euthanasia almost doubled – in 2013 approximately 6% of patients who died made such a request, whereas only approximately 3.4% made this request in 2007. Also the previously underrepresented groups now made such requests (e.g. older people and non-cancer patients). Possible explanations for this observed change can be the increasing acceptance of euthanasia among the general population, which continues to increase strongly particularly in Belgium and that values of autonomy and self-determination have gained importance (see next section). There could also be some purely demographic reasons: an increasing proportion of dying people is now highly educated and this is associated with more empowerment, less communication barriers, and thus more and more persuasive requests. Additionally, there may have been some societal normalization around the practice due to a heightened (and predominantly positive) attention in national media in recent years contributing to a discourse of euthanasia as one path among others to a dignified death (Van Brussel et al. 2014; Van Brussel/Carpentier 2014).

Second, the willingness of physicians to grant those requests had also increased considerably. The proportion of requests that were granted by
the physicians rose from 56.3% in 2007 to 76.8% in 2013. Physicians, being part of overall society, may increasingly share the prevailing discourse and societal perspective, raising their willingness to grant and perform euthanasia (and also in cases where they were previously more reluctant to do so).

The previous argument leads to the insight that there seems to be a growing overall acceptance among the general public and the physicians, which plays a key role and actually influences and shapes clinical end-of-life practice. The factors underlying and shaping this acceptance have become increasingly relevant to question.

4. Acceptance of euthanasia in society and the influence of cultural and sociodemographic factors

4.1 Acceptance of euthanasia across Europe

Two articles, one published in the European Journal of Public Health in 2013 (Cohen et al. 2013) and one in the International Journal of Public Health in 2014 (Cohen et al. 2014), using data from the European Values Study (EVS) have evaluated the euthanasia acceptance across Europe and the changes over time in that acceptance. In total, four survey waves were organized: wave 1 in 1981, wave 2 in 1990, wave 3 in 1999-2000, and wave 4 in 2008. The release of the 2008 data allowed, for the first time, to evaluate how the legalization of euthanasia in a number of countries and the ensuing intensified debate may have influenced the acceptance of euthanasia across Europe. They also allowed evaluating trends in acceptance in Eastern and Central European countries, as no data were available in the first wave for these countries. This was highly relevant as there are indications of a growing difference between Western Europe and Central and Eastern Europe in terms of public health, secularization of society, and political values (Cohen et al. 2006a; Laaksonen et al. 2001; Carlson 1998; Carlson 2004). This makes it highly likely that completely different trends in terms of euthanasia acceptance can be observed in Central and Eastern Europe.

The 2008 EVS data provide data for 47 European countries. In combination with data from previous waves this provides trend data 1981–2008 for 13 West-European countries: France, Great Britain, Germany, Italy, Spain, The Netherlands, Belgium, Denmark, Sweden, Iceland, Northern
Ireland, Ireland, Malta; and trend data 1990–2008 for twelve Central and Eastern European countries: Bulgaria, Czech Republic, Hungary, Latvia, Lithuania, Poland, Romania, (former) East Germany, Slovakia, Slovenia. With the data three aims were addressed: 1) to describe the acceptance of euthanasia in 2008 in 47 European countries and evaluate the factors associated with a country’s acceptance of euthanasia; 2) to describe trends in acceptance of euthanasia for European countries 1981-2008 and; 3) to evaluate whether different trends occurred in Western and Eastern Europe.

Apart from a number of questions about religious beliefs, attitudes towards various issues, and sociodemographic information, the questionnaire of the EVS includes one question on the acceptance of euthanasia (“Please tell me whether you think ‘Euthanasia (terminating the life of the incurably sick)’ can always be justified, never be justified, or something in between”) rated on a scale from 1 (‘Never justified’) to 10 (‘Always justified’).

A large variation in the acceptance of euthanasia across the 47 European countries was found, ranging from a very low mean score of acceptance in Kosovo to a very high mean acceptance score in Belgium and Denmark (Figure 2).

Countries with a particularly high average acceptance include (respectively) Denmark, Belgium, France, The Netherlands, Sweden, Luxembourg, Spain, Finland, Iceland, and Great Britain. The least accepting countries include Montenegro, Bosnia Herzegovina, Albania, Malta, Moldova, Armenia, Georgia, Turkey, Cyprus, and Kosovo. If illustrated on a map of Europe these average acceptance rates suggest some kind of geographical clustering (Figure 3). The area within the red lines on Figure 3 seems to contain the cluster of countries with a high acceptance of euthanasia, albeit with Germany and Austria being somewhat exceptions.
Figure 2: Acceptance of euthanasia in 47 European countries

Reference: Cohen et al. 2014
Minimum acceptance score = 1 (never justified), maximum acceptance score = 10 (always justified).
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Figure 3: Map of Europe in terms of acceptance of euthanasia

Map made using R software (packages Maps, Mapdata, Maptools)
Reference: Cohen et al. 2014
Footnote: Minimum acceptance score = 1 (never justified), maximum acceptance score = 10 (always justified). Based on the average scores for acceptance the following classification was made:
l ≤ 2.99 = very low acceptance
3.00-3.99 = low acceptance
4.00-4.99 = middle acceptance
5.00-5.99 = high acceptance
≥ 6.00 = very high acceptance
If looking at trend data (Cohen et al. 2013), there has been a continuous increase in acceptance of euthanasia in Western Europe between 1981 and 2008. Also, in the last decade (between 1999 and 2008) most countries saw a strong increase in their euthanasia acceptance (e. g. in UK, Spain, Belgium). The Belgian trends illustrate that there has been a particularly strong increase of acceptance in the period in which euthanasia was legalized in the country. In 2008 it surpassed the Netherlands in its tolerance towards euthanasia (which may be one explanation for the higher actual euthanasia incidence in Belgium than in The Netherlands, as discussed in the previous section). Interestingly, in The Netherlands there was no significant increase in the euthanasia acceptance between 1999 and 2008, i. e. comparing the time before legalization with the time after. In Central and Eastern European countries we find an entirely different pattern as compared to Western Europe with no significant increase or even a significant decrease in acceptance between 1999 and 2008 in all countries (except Bulgaria and Hungary).

4.2 Reasons for the cross-national differences in acceptance and in trends of acceptance of euthanasia

Several reasons for these observed differences could be identified in the data.

A first one is religiosity. Figure 4 illustrates that the average acceptance of euthanasia (x-axis) within a country is strongly associated with the level of religiosity (y-axis). Roughly, five clusters of countries can be distinguished: a cluster of high acceptance and low levels of religiosity (The Netherlands, Belgium, Denmark, France, Sweden), a cluster of rather acceptance with relatively low levels of religiosity, a cluster of average acceptance with average levels of religiosity (with Germany and Czech Republic being somewhat exceptions: their levels of religiosity are low but their euthanasia acceptance is average), and then two clusters of more religious and low accepting countries.
Figure 4: Average euthanasia acceptance in the 47 countries by their levels of religiosity

Minimum acceptance score = 1 (never justified), maximum acceptance score = 10 (always justified). Degree of religiosity is a standardized factor score calculated on the basis of nine questions: ‘the importance of religion in one’s life’, ‘frequency of attending religious services’, ‘does one consider oneself to be a religious person’, ‘belief in God’, ‘belief in spirit or life force’, ‘the importance of God in one’s life’, ‘getting comfort and strength from religion’, ‘taking moments of prayer or meditation’ and ‘frequency of praying to God outside religious services’. On the basis of this subset, a religiosity score was computed for each respondent (standardized factor score), with a higher score indicating a higher level of religiosity.

In the trend data, a decline in religiosity partly explained the increased euthanasia acceptance in Western Europe (Cohen et al. 2013). In The Netherlands – where we found no increase in euthanasia acceptance between 1999 and 2008 (see above) – no significant decline in religiosity was found between 1999 and 2008. Similarly, we found that slight increases in religiosity in Central and Eastern Europe partly explained the observed trends in euthanasia acceptance in Central and Eastern Europe.

Figure 5: Average euthanasia acceptance in the 47 countries by their levels of belief in the right to self-determination

Minimum acceptance score = 1 (never justified), maximum acceptance score = 10 (always justified). Degree of belief in the right to self-determination is a factor score calculated on the basis of the acceptance of seven items: divorce, abortion, homosexuality, having casual sex, prostitution, suicide, and in vitro fertilization. On the basis of this subset, a score was computed for each respondent (standardized factor score), with a higher score indicating a higher level of permissiveness.

A second important explaining factor is the tolerance towards personal choices in life. Figure 5 illustrates how the average acceptance of euthanasia (x-axis) within a country is strongly associated with the level of tolerance towards freedom of personal choices (alternatively named ‘belief in the right to self-determination’) – a scale composed of items that do not measure personal preferences or predispositions, but capture the extent to which people accept that others make personal (life and death) choices. There is a very strong almost linear association between both (even stronger than for religiosity). Countries further below the linear trend line indicate countries with a euthanasia acceptance that is higher than could be expected based on their overall tolerance towards freedom of personal choices (e.g. Belgium), while those further above the linear trend line represent those for which the euthanasia acceptance is relatively lower when compared with their tolerance towards freedom of personal choice items (e.g. Sweden and Greece).

The increase in tolerance towards freedom of personal choices between 1981 and 2008 also explained a substantial part of the increased euthanasia acceptance in Western Europe in that period. In Central and Eastern European countries the absence of an increase in euthanasia acceptance (particularly between 1999 and 2008) seems to coincide with an absence of an increase in the tolerance towards freedom of personal choices (Cohen et al. 2013).

A number of other factors also seem to play a role. The level of trust is one. An article by Vanessa Köneke (Köneke 2014), using the same data looked at the association between levels of trust and euthanasia acceptance. She operationalized trust in four different agents: 1) the health care system, 2) people in general, 3) state institutions, and 4) the press. She found that, at the country level, high levels of trust in other people, as well as high levels of confidence in the health care system were associated with a higher acceptance of euthanasia (although the effects were modest). Having trust in physicians may be crucial in accepting euthanasia as it requires someone to trust that the physician will respect his autonomy and dignity. A high level of trust in existing political and legal institutions also implies being more confident that future developments could be stopped should they turn out to be negative. Low levels of trust overall will lead to more concerns about possible abuse and a higher reluctance to eventually legalize euthanasia. Of note is that the effects of trust were stronger on a country-level than on an individual level, which suggests importance of the wider environment in shaping individual attitudes. Another country-le-
vel factor that likely plays a role is exposure to euthanasia (both in the media and in actual practice). In Belgium, the increased acceptance of euthanasia can be related to a frequent media coverage of euthanasia and a rather positive discourse around euthanasia in the hegemonic media (Van Brussel et al. 2014; Van Brussel/Carpentier 2014). Next to the media discourse, however, the visible experience with (and exposure to) euthanasia in Belgium (a 4.6% prevalence of euthanasia means that many people have experienced a person having received euthanasia in their family or friends; and there are no reported cases of obvious abuse) likely creates an environment that additionally influences acceptance of euthanasia.

5. Conclusions

In this article, I have discussed several indicators of increased acceptance of assisted dying in large parts of Europe and beyond. A first indicator is that an increasing number of countries and states have accepted legalization of assisted dying and others are considering legalization. A second is that, in countries that have a euthanasia law and that have conducted large-scale population-based studies evaluating end-of-life practices – i.e. The Netherlands and Belgium, albeit particularly in Belgium – there is an increasing proportion of dying people that request euthanasia and there is an increasing willingness of physicians to grant these requests. A third is that repeated surveys among the general public indicate that euthanasia acceptance has substantially increased over the last few decades (and continues to increase) in most or all Western European countries. This situation is different in Central or Eastern European countries where the acceptance often did not increase, or even decreased, in the last decade.

I have focused on country differences in euthanasia acceptance and country-level factors that explain these differences. These country-level factors (characteristics of environment) are a reality and influence attitudes towards euthanasia apart from individual characteristics or cognitive predispositions (Figure 6).
I have discussed how euthanasia acceptance is influenced by country-levels of religiosity, of tolerance towards personal autonomy and of trust, but also exposure to euthanasia (both through social constructions of euthanasia in the media but also exposure in practice). These country-level factors, of course, influence individual level factors but will have an influence on euthanasia acceptance in itself. It seems plausible, however, that these factors do not only influence individuals’ acceptance of euthanasia but also influence a country’s political stances towards regulating euthanasia. In that sense it seems highly likely, based on the findings I presented, that there is a cluster of countries where regulation of euthanasia will continue to be on the agenda and that it is likely that those countries will at some point adapt some law on assisted dying. On the other hand in a number of countries this seems unlikely. The situation is, for instance, completely different in most Central and Eastern European countries: good health care and high levels of trust in the health care system probably need to be in place before the debate can seriously address the option of euthanasia for reasons of dignity and autonomy.
References


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