Original Article

Attitude of doctors toward euthanasia in Delhi, India

ABSTRACT

Introduction: Deliberation over euthanasia has been enduring for an extended period of time. On one end, there are populaces talking for the sacrosanctity of life and on the other end, there are those, who promote individual independence. All over the world professionals from different areas have already spent mammoth period over the subject. A large number of cases around the world have explored the boundaries of current legal distinctions, drawn between legitimate and nonlegitimate instances of ending the life. The term euthanasia was derived from the Greek words "eu" and "thanatos" which means "good death" or "easy death." It is also known as mercy killing. Euthanasia literally means putting a person to painless death especially in case of incurable suffering or when life becomes purposeless as a result of mental or physical handicap.

Objective: To study the attitude of doctors toward euthanasia in Delhi.

Methodology: It was a questionnaire based descriptive cross-sectional study carried out between July 2014 and December 2014. The study population included Doctors from 28 hospitals in Delhi both public and private. Equal numbers of doctors from four specialties were included in this study (50 oncologists, 50 hematologists, 50 psychiatrists, and 50 intensivists). Demographic questionnaire, as well as the Euthanasia Attitude Scale (EAS), a 30 items Likert-scale questionnaire developed by (Holloway, Hayslip and Murdock, 1995) was used to measure attitude toward Euthanasia. The scale uses both positively (16 items) and negatively (14 items) worded statements to control the effect of acquiescence. The scale also has four response categories, namely "definitely agree," "agree," "disagree," and "definitely disagree." The total score for the EAS was generated by adding all the sub-scales (question's responses). The demographic questionnaire and EAS, a 30 items Likert-scale questionnaire developed by (Holloway, Hayslip and Murdock, 1995) was distributed among the study population to assess the clarity and adequacy of the questions. Reliability and content validity of the questionnaire were established. Reliability was calculated by "Cronbach Alpha" and the value computed was 0.839 the pilot study was conducted in a subset of 30 persons from the same study universe. Data were analyzed using Stata 11.2 and all the $P < 0.05$ were considered as statistically significant. Association of categorical variables among the groups was compared by using Chi-square/Fisher's exact test. Student's *t*-test was used to compare mean values in the two independent groups, and one-way ANOVA was used for more than two groups. A total of 200 questionnaires were returned out of 400, giving a response rate of 50%.

Analysis and Results: Our study provided the evidence that all doctors who responded to the questionnaire knew term euthanasia. This could be due to the fact that these professionals are in close association with issues pertaining to euthanasia in their day to day work. No significant difference seen in the attitude of doctors of different age group toward euthanasia, although younger doctors endorse robustly for euthanasia. This may be because younger doctors are open for addressing these debatable issues proactively. We found no association between gender and attitude toward euthanasia in our study.

Conclusion: It is evident from our study that oncologists, hematologists, psychiatrist, and intensivists do not support active euthanasia at all. There is a strong voice in support of voluntary passive euthanasia among psychiatrists and intensivists in our study. However, oncologists and hematologists are not in favor of passive euthanasia.

Key words: Attitude; euthanasia; letting die; mercy killing; palliative car.

Introduction

Deliberation over euthanasia has been enduring for an extended period of time. On one end, there are populace stalking for the sacrosanctity of life and on the other end, there are those, who promote individual independence. All over the world professionals from different areas have already spent mammoth period over the subject. A large number of cases

Access this article online	
Website: www.asjo.in	Quick Response Code
DOI: 10.4103/2454-6798.165115	

Sheetal Singh, Sharma DK[1], Vijay Aggarwal[2], Preeti Gandhi[3], Sajjan Rajpurohit[4]

Departments of Hospital Administration and [1]Medical Superintendent, All India Institute of Medical Sciences, [2]General Manager, Max Hospital, Pitampura, [4]Department of Medical Oncolgy, Rajiv Gandhi Cancer Institute and Research Centre, New Delhi, India [3]Consultant Gynaecologist, Scunthorpe General Hospital, Scunthorpe, UK

Address for correspondence: Dr. Sheetal Singh, Department of Hospital Administration, All India Institute of Medical Sciences, Ansari Nagar, New Delhi - 110 029, India.
E-mail: sheetalsingh2003@hotmail.com

How to cite this article: Singh S, Sharma DK, Aggarwal V, Gandhi P, Rajpurohit S. Attitude of doctors toward euthanasia in Delhi, India. Asian J Oncol 2015;1:49-54.

around the world have explored the boundaries of current legal distinctions, drawn between legitimate and nonlegitimate instances of ending the life.[1] There are 2 main forms of euthanasia, namely; active euthanasia which is a positive merciful act to end useless sufferings and a meaningless existence.[2] On the other hand, passive type is to discontinue or not use extraordinary life-sustaining measures to prolong life.[2]

The deliberation on euthanasia has now become increasingly important as countries such as The Netherlands, Canada, Oregon, Belgium, and Columbia support euthanasia. Globally laws around the world differ and are constantly subject to changes as alteration in cultural values, better palliative care and treatment becomes available.

The term euthanasia was derived from the Greek words "eu" and "thanatos" which means "good death" or "easy death." It is also known as mercy killing. Euthanasia literally means putting a person to painless death especially in case of incurable suffering or when life becomes purposeless as a result of mental or physical handicap.[3] The purpose of life is to be happy and to make others happy if possible, to grow old gracefully, and to die with dignity. Hence, the question of euthanasia arises on three occasions.[4]

- At the beginning of life (at birth)
- At the end of natural life (terminal stage)
- When a person is severely impaired as a result of brain damage (unforeseen mishap).

At birth

In case of physically and mentally handicapped infants decision rests with the parents or the doctors aided by the law of the land.[5] The decision should be based on the quality of life the child can expect and its consequent impact on the parents, society and the resources of the state and also care of the child after the death of the parents. In The Netherlands neonatal and infant deaths preceded by the intentional administration of life-shortening drugs are known to take place, although rarely.[6]

At terminal stage

The dying conscious patient can give his own consent to continue or stop the on-going treatment if he/she wishes to.[7]

Unforeseen mishap

When a person is severely impaired as a result of brain damage either due to violence, poisoning or natural causes where the brain suffers from hypoxic brain damage from, which it cannot recover irrespective of the treatment given his life can be sustained by artificial means, but only in a state of suspended animation. This gives rise to the confusion whether the treatment is prolonging life or death. In such cases, he/she may be allowed to die in comfort and with dignity.

Types of euthanasia:[3]

- Active
- Passive also known as letting die
- Voluntary
- Involuntary
- Nonvoluntary.

Active euthanasia

It means a positive merciful act to end useless sufferings and a meaningless existence. It is an act of commission for example by giving large doses of a drug to hasten death.

Passive euthanasia

Implies discontinuing or not using extraordinary life-sustaining measures to prolong life. Others include the act of omission, such as failure to resuscitate a terminally ill or incapacitated patient, for example, a severely affected newborn with hypoxic ischemic encephalopathy. Other methods include discontinuing a feeding tube, denying life-extending operation, or medications.

"Letting die" means to give way to an on-going inner-organism process of disintegration, without supporting or substituting vital functions. Therefore, the extubation (removal from a ventilator) of an incurably ill patient, though a physical action with subsequent death, is not killing in its proper meaning. The extubation does not produce the effect of death; it only influences the time of its occurrence. The lethal injection kills both the ill, as well as the healthy person. The discontinuation of life-sustaining treatment, however, only causes the death of the mortally ill, whereas on the healthy individuals it would have no effect at all.

Voluntary

When the euthanasia is practiced with the expressed desire and consent of the person concerned.[8]

Nonvoluntary

When it is practiced without the scope to make the desire of the subject available.[8]

This includes cases where:

- The person is in a coma
- The person is too young (e.g., a very young baby)
- The person is demented
- The person is intellectually disabled to a very severe extent
- The person is severely brain damaged

- The person is mentally disturbed in such a way that they should be protected from themselves."

Involuntary

When the euthanasia is practiced against the will of the person.

Euthanasia cannot be compared to assisted suicide because in assisted suicide, the third party only assists in the termination of life by a person, and he does not *per se* terminate the life. However, in case of euthanasia the third party is actively involved in the termination of life by means of his act or omission. While assisted suicide refers to the self-termination of life, euthanasia refers to the termination of life by the intervention of a third person. Further suicide may be committed for various reasons ranging from family to financial, societal to medical and so on. However, euthanasia, in its strict sense, is confined to the cases where a person is in a serious medical condition.

Assisted suicide: Someone provides an individual with the information, guidance, and the means to take his or her own life with the intention that they will be used only for this purpose. When it is a doctor, who helps another person to kill themselves, it is called "physician-assisted suicide or doctor-assisted suicide."[3]

In doctor assisted-suicide, the doctor provides the patient with relevant medical information (i.e., discussing painless and effective medical means of committing suicide), enabling the patient to end his/her own life.

The objective of the present study was to study the attitude of doctors toward euthanasia in Delhi.

Methods

Sample and procedure

It was a questionnaire based descriptive cross-sectional study carried out between July 2014 and December 2014. The study population included doctors from 28 hospitals in Delhi both public and private. Equal numbers of doctors from four specialties were included in this study (50 oncologists, 50 hematologists, 50 psychiatrists, and 50 intensivists). The demographic questionnaire, as well as the Euthanasia Attitude Scale (EAS), a 30 items Likert-scale questionnaire developed by (Holloway, Hayslip and Murdock, 1995) was used to measure attitude toward Euthanasia. The demographic questionnaire and EAS, a 30 items Likert-scale questionnaire developed by (Holloway, Hayslip and Murdock, 1995) was distributed among the study population to assess the clarity and adequacy of the questions. Reliability and content validity of the questionnaire were established. Reliability was calculated by "Cronbach Alpha" and the value computed was 0.839 the pilot study was conducted in a subset of 30 persons from the same study universe.

The scale uses both positively (16 items) and negatively (14 items) worded statements to control the effect of acquiescence. The scale also has four response categories, namely "definitely agree," "agree," "disagree," and "definitely disagree." In order to quantify the items, numbers that range from 4 to 1 were given to the positive items. Numbers for the negative items have been reversed. The scale provides a total score, which may range between 30 and 120, with scores between 75 and 120 indicating endorsement of euthanasia and scores <75 as an indication of a negative attitude toward euthanasia. The total score for the EAS was generated by adding all the sub-scales (question's responses).

Data were analyzed using Stata 11.2 and all the $P < 0.05$ were considered as statistically significant. Association of categorical variables among the groups was compared by using Chi-square/Fisher's exact test. Student's *t*-test was used to compare mean values in the two independent groups, and one-way ANOVA was used for more than two groups.

Analysis and Results

Purposive sampling was carried out. Of 400, 200 questionnaires were returned, giving a response rate of 50%. All the respondents were aware of the term euthanasia.

As shown in Table 1, the mean of the total scores for the EAS was found statistically significant ($P = 0.03$) among doctors (oncologists, psychiatrists, intensivists, and hematologists). Mean score of EAS for oncologist and hematologist are 73.4 and 72.2, respectively, which signifies that oncologist do not endorse euthanasia while mean score of EAS for psychiatrists and intensivists are 87.4 and 86.6 while signifies that they strongly endorses euthanasia.

As seen in Table 2 no significant difference is seen in the attitude of doctors in different age groups toward euthanasia, ($P = 0.09$) by using one-way analysis, although doctors' in the age group 30–40 years endorses strongly for euthanasia.

Similarly, there was no significant difference observed in the attitude of professional groups of the opposite sex toward euthanasia ($P = 0.95$) as seen in Table 3.

About 87% of oncologists and 82% hematologists believe that no action should be taken to induce death even if death is preferable to life in a terminally ill patient whereas, 74% of the psychiatrist and 63% of the intensivist disagree with the same ($P = 0.03$).

74% of psychiatrist 72% intensivists, support the practice of comfort measures only and allow dying in peace without further life-prolonging treatment, whereas 81% of the oncologist and 77% hematologists disagree with the view ($P = 0.02$). 90% intensivists, 88% psychiatrist 82% oncologists, and 80% hematologists are against keeping a brain dead person alive with proper medical care ($P = 0.001$).

80% psychiatrists, 77% of intensivists were of the opinion that a person with a terminal and painful disease should have the right to refuse/reject life-sustaining/support treatment, however 67% oncologists and 61% hematologists do not hold the same opinion ($P = 0.01$).

86% of psychiatrists, 70% intensivists, 68% of the oncologist and 54% hematologists are of the view there should be no ill feelings toward a person who hastens the death of a loved one to spare them from further unbearable pain ($P = 0.004$).

82% of the oncologists, 72% hematologists, 60% of the psychiatrists and 59% intensivists are of the view that there should be legal possibilities by which an individual could preauthorize his/her own death, should intolerable illnesses arise ($P = 0.01$).

Table 1: Mean of the total scores for the EAS

	Mean±SD				*P*
	Psychiatrists (*n*=50)	Intensivists (*n*=50)	Oncologists (*n*=50)	Hematologists (*n*=50)	
EAS	87.4±11.4	86.6±10.5	73.4±7.5	72.2±10.3	0.03

EAS - Euthanasia attitude scale; SD - Standard deviation

Table 2: Attitude of the professionals in different age groups toward euthanasia

	Mean±SD				*P*
	31-40 years (*n*=45)	41-50 years (*n*=55)	50-60 years (*n*=60)	≥60 years (*n*=40)	
EAS	87.7±11.55	82.1±17.10	80.3±11.37	80.6±10.35	0.09

EAS - Euthanasia attitude scale; SD - Standard deviation

Table 3: Attitude of professional groups of opposite sex toward euthanasia

	Mean±SD		*P*
	Males (*n*=134)	Female (*n*=76)	
EAS	84.32±15.9	82.21±8.86	0.90

EAS - Euthanasia attitude scale; SD - Standard deviation

81% psychiatrists, 75% intensivists, approves that terminally ill person in severe pain deserves the right to have his/her life ended in the easiest way possible however, 65% oncologist and 57% hematologists disagree with the same ($P = 0.02$). 75% of the psychiatrist, 71% intensivist, 52% oncologist and 50% hematologists supports a doctor's decision to reject extraordinary measures if a patient has no chance of survival however of the nurses disagree with it ($P = 001$).

80% of the oncologist, 76% Hematologist, 65% psychiatrist and 54% intensivist believe that the administration of a legal dose of some drug to a person in order to prevent him from dying an unbearably painful death is unethical. 77% of the oncologist, 52% of hematologist 50% of the psychiatrist and 50% intensivists disagree with the view of inducing death for merciful reasons ($P = 0.03$). 77% intensivists and 62% psychiatrists are against forceful parenteral feeding for terminally ill patients, 55% oncologist and 53% hematologist disagree with this view ($P = 0.02$). 62% Oncologist and 55% Hematologist are of the opinion that the termination of a person's life, done as an act of mercy, is unacceptable to them, whereas psychiatrists, intensivists are equivocal in this view ($P = 0.60$).

Discussion

Our study provided the evidence that all doctors who responded to the questionnaire knew term euthanasia. This could be due to the fact that these professionals are in close association with issues pertaining to euthanasia in their day to day work. No significant difference seen in the attitude of doctors of different age group toward euthanasia, although younger doctors endorse robustly for euthanasia. This may be because, younger doctors are open for addressing these debatable issues proactively.

We found no association between gender and attitude toward euthanasia in our study. Our results were similar to the study by Kamath *et al*., where they found no difference in the attitude among doctors of different age group and opposite sex similar to our study.[9] Similarly,[2] in their study found no significant correlation between the attitude of elderly people toward euthanasia and variables like gender.

It is evident from our study that oncologists, hematologist, psychiatrist, and intensivists do not support active euthanasia at all. There is a strong voice in support of voluntary passive euthanasia among psychiatrists and intensivists in our study. However, oncologists and hematologists are not in favor of passive euthanasia. Our findings resonate with the study by Cohen *et al*. in the year 1994 who found that hematologists

and oncologists were most likely to oppose euthanasia and psychiatrists were most likely to support these practices.[10] In another study Glebocka *et al*., who found that the attitude toward a passive form of euthanasia seems to have broader support among Polish physicians, nurses, and people who have no professional experience with the terminally ill. They also concluded that doctors, particularly tend to approve the passive form of euthanasia. The active euthanasia was less favored and physicians, in particular, appeared to disapprove of it.[11] In another interesting study done in the year 2011 by Yun *et al*. it is established that oncologists have a negative attitude toward euthanasia and physical associated suicide.[12]

All the doctors viz: Oncologists, hematologist, psychiatrists, and intensivists consider active euthanasia as unethical in our study. Opinion of the health professionals on active euthanasia vary widely between countries.[6] The study by Cuttini *et al*. showed that more than half of the doctors in The Netherlands and only a quarter in France favored legalizing active euthanasia. It was even less acceptable in other European countries as Lithuania and Sweden.

Oncologists and hematologist do not support patient's choice and their rights. They believe that terminally ill patients should not have the right to end their life, and to reject any life-sustaining/support/additional/extraordinary treatment. This finding of our study is in consonance with the study carried out in U.S in the year 2000 by Emanuel *et al*. in which it is evident that requests for euthanasia are likely to decrease as training in end of life improves, and the ability of physicians to provide this care is enhanced.[13] Doctors of all specialties mentioned in the study are of the view that there should be legal avenues by which an individual could choose to make advance directives, which allow the individuals to express and document their treatment preferences at the time when they are competent and to inform health care professionals how they would like to be treated in case of incompetency.[14]

In our study, intensivists and psychiatrists support the practice of comfort measures only and allow dying in peace without further life-prolonging treatment, whereas oncologists and hematologists are against this view. This could be interpreted as oncologists are trained for treating terminally ill patients and support palliative care. An interesting study conducted by Bendiane *et al*. (2003) found that French doctors wanted euthanasia to be legalized. This opinion was more common among the general practitioners and neurologists than the oncologists, who were more experienced in end of life care, better trained in palliative care, and show greater comfort and better communication with terminally ill patients. Gielen *et al*. showed that physicians working in palliative care in Delhi favor the practice of painkillers such as morphine and palliative sedation to keep the patient comfortable. This shows that attitude of doctors toward various components of euthanasia varies with their training and their experience of caring in for terminally ill patients.[15]

Recommendations

There is a strong voice in support of voluntary passive euthanasia among psychiatrists and intensivists though oncologist and hematologists are not in favor of passive euthanasia. The majority of doctors of different specialties viz: Oncologists, hematologists, psychiatrists, and intensivists considered active euthanasia as unethical in our study. We recommend exploring advanced directives like "Do Not Attempt Resuscitation" in a terminally ill patient, or decision regarding use of life-saving treatment in specific illnesses where capacity or consent may be impaired, which are widely practiced in the United Kingdom. In addition, we recommend development of robust palliative care guidance to control pain and suffering of terminally ill patients.[3,14-16]

Direction for Future Research

This study examined the attitudes of oncologists, hematologists, psychiatrist, and intensivists of our society. However, the viewpoints of doctors of various other specialties viz: Pediatrics, neurosurgeons, general physician, surgeons on euthanasia should be sought in order to get a comprehensive view of the topic concerned. Upcoming research should try to discourse these limitations. The results of this study have important implications on doctors and policy makers. Despite the lack of consensus on some issues, a substantial number of responders believe that voluntary passive euthanasia should be supported by a legal system of our country.

We propose larger study at the national level to scrutinize the acceptability of voluntary passive euthanasia among wider population including terminally ill individuals, and this would help the lawmakers to shape the future of Euthanasia in our Country.

Strengths

Our study has several strengths. We used validated questionnaire like EAS to measure the attitude toward euthanasia. The population sample included doctors from various specialties who are directly or indirectly related to decision making around Euthanasia.

Limitations

One of the key limitations of our study was that we did not take the views of nurses, patients, and their family members. The other issue is that the outcomes of this study cannot be generalized as this study conducted was in one of the city of India.

Financial support and sponsorship
Nil.

Conflicts of interest
There are no conflicts of interest.

References

1. Fernandes AK. Euthanasia, assisted suicide, and the philosophical anthropology of Karol Wojtyla. Christ Bioeth 2001;7:379-402.
2. Ramabele T. Attitudes of the Elderly Towards Euthanasia: A Cross-Cultural Study. [dissertation]. South Africa. University of the Free State; 2004.
3. Murkey PN, Singh KS. Review article euthanasia [mercy killing]. J Indian Acad Forensic Med 2008;30:92-5. Available from: http://www.medind.nic.in/jal/t08/i2/jalt08i2p92.pdf.
4. Sinha VK, Basu S, Sarkhel S. Euthanasia: An Indian perspective. Indian J Psychiatry 2012;54:177-83.
5. Shepperdson B, Sociology M. Abortion and euthanasia of Down's syndrome children – The parents view. J Med Ethics 1983;9:152-7.
6. Cuttini M, Casotto V, Kaminski M, de Beaufort I, Berbik I, Hansen G, *et al.* Should euthanasia be legal? An international survey of neonatal intensive care units staff. Arch Dis Child Fetal Neonatal Ed 2004;89:F19-24.
7. Robben S, van Kempen J, Heinen M, Zuidema S, Olde Rikkert M, Schers H, *et al.* Preferences for receiving information among frail older adults and their informal caregivers: A qualitative study. Fam Pract 2012;29:742-7.
8. Csikai EL. Euthanasia and assisted suicide: Issues for social work practice. J Gerontol Soc Work 1999;31:49-63.
9. Kamath S, Bhate P, Mathew G, Sashidharan S, Daniel AB. Attitudes toward euthanasia among doctors in a tertiary care hospital in South India: A cross sectional study. Indian J Palliat Care 2011;17:197-201.
10. Cohen JS, Fihn SD, Boyko EJ, Jonsen AR, Wood RW. Attitudes toward assisted suicide and euthanasia among physicians in Washington State. N Engl J Med 1994;331:89-94.
11. Glebocka A, Gawor A, Ostrowski F. Attitudes toward euthanasia among Polish physicians, nurses and people who have no professional experience with the terminally ill. Adv Exp Med Biol 2013;788:407-12.
12. Yun YH, Han KH, Park S, Park BW, Cho CH, Kim S, *et al.* Attitudes of cancer patients, family caregivers, oncologists and members of the general public toward critical interventions at the end of life of terminally ill patients. CMAJ 2011;183:E673-9.
13. Emanuel EJ, Fairclough D, Clarridge BC, Blum D, Bruera E, Penley WC, *et al.* Attitudes and practices of U.S. oncologists regarding euthanasia and physician-assisted suicide. Ann Intern Med 2000;133:527-32.
14. Kelner M, Bourgeault IL, Hébert PC, Dunn EV. Advance directives: The views of health care professionals. CMAJ 1993;148:1331-8.
15. Gielen J, Gupta H, Rajvanshi A, Bhatnagar S, Mishra S, Chaturvedi AK, *et al.* The attitudes of Indian palliative-care nurses and physicians to pain control and palliative sedation. Indian J Palliat Care 2011;17:33-41.
16. Kouwenhoven PS, Raijmakers NJ, van Delden JJ, Rietjens JA, Schermer MH, van Thiel GJ, *et al.* Opinions of health care professionals and the public after eight years of euthanasia legislation in the Netherlands: A mixed methods approach. Palliat Med 2013;27:273-80.