# How Hawaii's Doctors Feel about Physician-Assisted Suicide and Euthanasia: An Overview

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*We polled, by questionnaire, all doctors and medical trainees in Hawaii (n=3,017) to determine their attitudes towards physician-assisted suicide, euthanasia and other end-of-life medical issues. One thousand and twenty-eight (34.1 %) responded. Medical trainees did not differ significantly from practicing physicians. Only a minority of respondents (15.6%) were willing to assist a terminally-ill patient to commit suicide. An even smaller number (9.8%) would perform active euthanasia. On the other hand, an overwhelming majority would withhold (97.6%) or withdraw (78.6%) life-support upon request. Most doctors (88.0%) were also willing to administer high doses of narcotics for pain relief, even if such therapy hastened death. About half the doctors felt that physician-assisted suicide and active euthanasia may be justified under some circumstances, although most were unwilling to personally carry out these acts. Catholic, Filipino and Hawaiian/Polynesian doctors were statistically less likely to approve of or perform physician-assisted suicide or active euthanasia.*

For much of this decade, both the medical and lay communities have actively debated the ethics of "mercy-killing". In November 1994, voters in Oregon voted to legalize physician-assisted suicide, after previous initiative votes failed in Washington and California.[1] Earlier this year, two appellate courts separately held that mentally competent patients who were terminally-ill had a constitutional right to physician assisted suicide.[2,3] Going one step beyond, the Northern Territory of Australia recently legalized the practice of euthanasia,[4] thereby joining the Netherlands[5] in allowing physicians to actively end, with consent, the lives of terminally-ill patients.

Are doctors for or against such practices? Published surveys[6-11] have generally found that a substantial minority in the medical profession is supportive of physician-assisted suicide and a smaller number of active euthanasia. To date, no data are available on the opinions of Hawaii's physicians. We therefore undertook such a survey concerning various end-of-life medical issues, including physician-assisted suicide and active euthanasia. Given Hawaii's limited and diverse population, we were able to mail questionnaires to all the physicians in the state, and to analyze the results for ethnic and religious differences.

## Methods

We mailed an anonymous questionnaire to all physicians, residents and medical students in Hawaii in September 1995. The questionnaire was patterned after that used in a recently published survey of Rhode Island physicians.[11] Two months later, we completed a second mailing. All results were entered into a computer data base and analyzed by SAS statistical analysis program. Chi-square testing was performed to determine statistical significance among the various demographic groups.

The questionnaire consisted of two main parts. In the first part of the questionnaire, we posed several clinical scenarios involving a hypothetical terminally-ill competent patient with lung cancer. A simple *yes/no* response was sought. In scenario 1, the patient requests not to be intubated, although it appears he will not survive otherwise (withholding treatment). Scenario 2 describes the same patient who requests narcotics for pain relief in doses that might hasten death through respiratory depression. In scenario 3, the patient, having been emergently intubated by another physician, now requests that the endotracheal tube be removed (withdrawing treatment). Scenario 4 describes the patient's request for a medication prescription with the specific intent to end his life (physician-assisted suicide). In the 5th and last scenario, the patient seeks death via a lethal injection to be administered by the physician (active euthanasia).

For each *yes/no* response, the surveyed physicians were ask to select, in rank order, various reasons why they so decided. The analysis of these results will be reported in a later communication.

In the second part of the questionnaire, we asked about general attitudes towards physician-assisted suicide and active euthanasia. We asked whether physicians would approve of these practices in some circumstances (unstipulated), and whether they would personally perform such acts. We also asked whether they had actually performed these acts in the past.

## Results

Three thousand and seventeen physicians, residents and medical students were polled. Of these, 1,028 responded for an overall response rate of 34.1 %. Two hundred and seventeen (21.1%) of the respondents were trainees. There were 139 medical students and 78 residents. Their views did not differ significantly from those of practicing physicians.

Demographic data of the respondents are shown in Table 1.

The responses of physicians (this term is used to include residents and medical students) to the five described clinical scenarios (Part 1 of questionnaire) are tabulated in Table 2 and shown graphically in Figure 1. The vast majority would withhold (97.6%) or withdraw (78.6%) treatment, or give narcotics for pain relief even if they hastened death (88.0%). However, only a minority would perform physician-assisted suicide (1 5.6%) or active euthanasia (9.8%).

Table 3 tabulates the general attitudes of the respondents (Part 2 of

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questionnaire). A slight majority would approve of physician-assisted suicide (60.0%) or active euthanasia (58.6%) under some (unspecified) circumstances. A much smaller percentage would personally perform these acts (28.8% and 27.6% respectively). Four percent of respondents indicated that they had assisted their patients to commit suicide, and 3.5% said they had personally performed active euthanasia.

Table 4 depicts ethnic and religious differences. Catholics (n=195) were the only religious group that consistently showed a statistically lower rate of support for physician-assisted suicide or active euthanasia. Among the various ethnic groups, Filipino (n=41) and Hawaiian/Polynesian (n=35) doctors showed a definite trend towards being less likely to approve of or perform these acts. This trend persisted even after removing Catholic religious belief as a confounding variable. Non-Filipino Catholics appeared more likely than Filipino Catholics in their approval of physician-assisted suicide (45.3% vs 30%) and active euthanasia (42.3% vs 24.1%). In contrast to the religious and ethnic differences observed for physician-assisted suicide and active euthanasia, there were no differences observed for withholding and withdrawing life-support, and prescribing narcotics for pain relief.

No statistical differences in physician response were detected for subgroups classified by age, sex, specialty, years in practice, and place of practice.

## Discussion

1,028 physicians participated in this survey, making it one of the largest series, second only to Oregon's. This figure represents 34.1% of Hawaii's entire physician population. Unfortunately, we were unable to obtain reliable data on the demographics of Hawaii's physician population so that we could ascertain and confirm sample-match.

The results of our survey, the first carried out in the state of Hawaii, indicate that the vast majority of physicians would withhold or withdraw treatment in accordance with the request of a terminally ill patient. Likewise, Hawaii's physicians are quite willing to administer narcotics for pain relief, even in doses that may hasten death. These practices comport with generally accepted ethical precepts[12] set forth by professional organizations such as the American College of Physicians[13] and by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research.[14] Our results closely parallel those obtained in the 392 physicians of Rhode Island who were surveyed using a similar questionnaire.[11]

Regarding assisting a patient to commit suicide, our figure of 15.6% is virtually identical to that obtained in a much smaller and defined group in Florida.[10] There, 16% of physicians (360 medical faculty and trainees at the University of Miami) stated that they would perform the act, compared to 15.6%-28.8% of our physicians. In Rhode Island, only 9% would do so.[11] In contrast, the figure was a third in Michigan,[7] 40% in the state of Washington,[9] and nearly one half in Oregon.[6]

Fewer than 1 in 10 physicians in the state of Hawaii would personally perform active euthanasia when faced with a hypothetical patient making such a request. Published figures from other surveys range from 1 % in Rhode Island[11] to 33% in Washington.[9]

Oregon's physician survey on physician-assisted suicide is the largest yet published, and involved 2,761 physicians who were deemed eligible to prescribe a lethal dose of medication.[6] Sixty percent thought such an act should be legal in some cases; 46% might be willing to prescribe, and 31% were unwilling on moral grounds. Although a similar percent of our respondents would approve of physician-assisted suicide under some unspecified circumstances, Hawaii's physicians appear much less likely to become personally involved, especially when confronted with a specific case scenario. These differences appear to be real; 36 physicians in Hawaii reported that they had performed physician-assisted suicide (4%), a frequency almost half that of Oregonian physicians (7%).

Why is it that under some unspecified circumstances, slightly more than half of our physicians could approve of both physician-assisted suicide and active euthanasia, yet only about a quarter would personally perform these acts? This disparity between "general approval under some circumstances" and actual performance has been noted in other surveys.[6,9] We attribute the reluctance of personal involvement to cultural and religious factors, prior medical teaching, the lack of knowledge of how to proceed, the fear of criminal liability, and insecurity regarding the true meaning of such patient requests. This last factor may prove determinative. In a recent survey of oncologists, for example, Emanuel et al[15] found that 45.5% agreed with physician-assisted suicide for cancer patients with unremitting pain, but this figure dropped to 35.5% for patients with functional debility, to 22.9% when the reason was burden on family, and to only 18.1% when life was viewed as meaningless.[15]

We identified ethnic and religious differences in our study. Catholic physicians as a group were consistently less likely to approve of or carry out physician-assisted suicide and active euthanasia. The same generally held true for Filipino and Hawaiian/Polynesian doctors, although with somewhat less statistical confidence. The ethnic differences appear real, persisting even after removing Catholic religious belief as a confounding variable. On the other hand, the views of these doctors did not differ from the entire group on the issues of withholding and withdrawing treatment, and prescribing narcotics for pain relief. Given Hawaii's heterogeneous population, divergent views are not surprising, especially since attitudes towards life, death and the dying process are deeply rooted in one's heritage and upbringing, and susceptible to both cultural and spiritual influences. Our results, however, do invite the inquiry into whether other end-of-life issues, e.g., hospice care and cardiopulmonary resuscitation, are race- and religion- sensitive, and whether these views are comparably shared by doctors as well as their patients.

How physicians in Hawaii feel about physician-assisted suicide and euthanasia is highly relevant, since they will be the ones called upon to effectuate such acts. Will Hawaii legalize these acts? At the federal level, appellate courts[2,3] in the second and ninth circuits have recently ruled that competent terminally-ill patients have a constitutional right to physician-assisted suicide. These cases have been appealed to the U.S. Supreme Court, which has agreed to hear oral arguments in January 1997. Its decision may well be a landmark in the annals of medical jurisprudence. Or it may take a neutral stance by deferring to the states for individual adjudication or legislation.

In 1993, state representative Terrance Tom, then chair of the House Judiciary Committee, conducted public hearings on these issues. Based on his findings, he rejected any form of euthanasia for the State of Hawaii, and instead introduced legislation to ensure that knowledge of modern pain-management therapy and comfort care was made available to every terminally-ill patient in need of such relief. Interestingly, Oregon's healthcare systems have responded to its 1994 pro-suicide vote, currently challenged in court, by instituting these same measures. If Hawaii's healthcare professionals would heed this "wake-up" call, they too can provide better comfort care to their patients at the end-of-life.

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**Table 1.—Demographics of Respondents (n=1.028) by Percent**

**Age:**
<40 years - 31.8
40 - 59 years - 45.9
60+ years - 22.3

**Sex:**
Male - 75.4
Female - 24.6

**Level of Training:**
Practitioner - 78.8
Resident - 7.6
Medical Students - 13.5

**Specialty:**
Medicine - 42.6
Surgery - 17.4
Pediatrics - 8.0
Psychiatry - 6.3
Others - 25.7

**Area of Practice:**
Urban - 68.1
Suburban - 19.7
Rural - 12.3

**Years in Practice:**
<10 years - 28.4
10 - 19 years - 26.3
20+ years - 45.4

**Ethnicity:**
Caucasians - 48.5
Japanese - 17.3
Chinese - 14.3
Other Asians - 10.2
Filipinos - 4.0
Hawaiian/Polynesian - 3.4
Other - 2.3

**Religion:**
Catholic - 19
Protestant - 14.1
Christian - 13.8
Buddhist - 5.6
Jewish - 4.4
**Episcopalian - 4.2**
None - 18.1
Other - 20.8

**Table 2.—Survey Results of 1,028 Hawaii Physicians* Regarding a Hypothetical Terminally-Ill Patient**

| | |
|---|---|
| Withhold treatment | 97.6% |
| Use narcotics to relieve pain even if death hastened | 88.0% |
| Withdraw treatment | 78.6% |
| Participate in physician-assisted suicide | 15.6% |
| Participate in active euthanasia | 9.8% |

*There were 139 medical students and 78 residents in the group. Separate analysis of the data from these trainees yielded differences that were statistically insignificant (data compared to those of practicing physicians).

**Table 3.—Survey Results of General Attitudes of 1,028 Hawaii Physicians**

| | |
|---|---|
| Approve of physician-assited suicide under some circumstances | 60.0% |
| Would personally perform physician-assisted suicide | 28.8% |
| Approve of active euthanasia under some circumstances | 58.4% |
| Would personally perform active euthanasia | 27.6% |

**Note:** 4% of respondents indicated they had personally assisted a patient to commit suicide; 3.5% said they had personally performed active euthanasia.

**Table 4.—Ethnic and Religious Differences in Physician Response**

| | **All Doctors** (n=1,028) | **Filipino** (n=41) | **Haw/Poly** (n=35) | **Catholic** (n=195) |
|---|---|---|---|---|
| *Hypothetical Scenarios in a Terminally-ill Patient* | | | | |
| Would favor: | | | | |
| Physician-assisted suicide | 160 (15.6%) | 2 (4.9%)+ | 1 (2.9%)*** | 13( 6.7%)* |
| Active euthanasia | 101 (9.8%) | 2 (4.9%)+ | 2 (5.7%) | 11 (5.6%)** |
| *General Attitudes* | | | | |
| Physician-assisted suicide: | | | | |
| Would Approve | 617 (60%) | 13 (31.7%)** | 14 (40%)*** | 83 (42.6%)* |
| Would Perform | 296 (28.8%) | 5 (12.2%)** | 5 (14.3%)+ | 27 (13.8%)* |
| Active euthanasia: | | | | |
| Would Approve | 600 (58.4%) | 11 (26.8%)* | 14 (40%)*** | 78 (40.0%)* |
| Would Perform | 284 (27.6%) | 7 (17.1%) | 8 (22.9) | 33 (16.9%)** |

(*) denotes p <0.001; (**) p<0.01; (***) p<0.05; (+) p<0.1>0.05. No statistical significance was found for other ethnic or religious categories

**Fig 1.— Medical Decisions in a Hypthetical Terminal Patient**