

ARTICLE

The Impact of Current Legislation on French People's Views Regarding Physician-Assisted Suicide

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Abstract

The impact of current legislation on French people's views regarding the perceived acceptability of physician-assisted suicide (PAS) was assessed. A total of 221 lay people and 101 health professionals judged the acceptability of PAS in 24 scenarios composed of all combinations of four factors: the patient's country of residence (the Netherlands or France), the patient's age (80 years or 50 years), whether another physician was invited to give an advice (yes or no), and the patient's request for a life-ending procedure (no request, some form of request, or repeated formal requests). In all scenarios, the patients were women who were receiving the best possible care. The ratings were subjected to cluster analysis and analyses of variance. Four clusters were found that were similar to those found in previous studies. For 50% of the participants, there was essentially no difference whether the patient resided in the Netherlands or in France, and for 25%, the difference was very small. For only 5% of the participants was the difference higher than 3.5 points (on a 0-15 point scale). People who usually find PAS either unacceptable or acceptable did not change their position to any significant extent when told that the current legislation in the patients' country allowed PAS. Opposition to PAS was thus not based on a strict respect for law and

* DOI 10.7590/221354014X13935789416813

acceptance of PAS was thus not based on ignorance of law. Participants clearly distinguished the domains of law and morality.

Introduction

Physician-assisted suicide (PAS) is highly controversial. It is legal in the Netherlands,¹ Belgium,² Luxembourg,³ Germany,⁴ Switzerland,⁵ and in the American states of Oregon,⁶ Washington,⁷ Montana,⁸ and (most recently) Vermont.⁹ Elsewhere in the Western (and non-Western) world PAS is against the law.

Nonetheless, surveys have repeatedly shown that, even in countries where it is illegal, most people in the Western world support painless euthanasia of incurably ill patients if they and their families request it from their doctors.¹⁰⁻¹³ In addition, studies focussing on people's judgment processes at the time of assessing acceptability have shown that they harbour three contrasting personal positions: (a) a majority consider that the acceptability of PAS strictly depends on circumstances, notably on the level of patients' requests for a life-ending procedure, (b) a minority consider that PAS is always unacceptable, and (c) another minority consider that it is always acceptable (in the circumstances depicted in the studies).^{14,15} Such qualitatively different personal positions have also been found in studies conducted in non-Western countries¹⁶⁻¹⁹ and in a study conducted on prosecution of physicians.²⁰

The present study assessed the impact of current legislation on people's views. It borrowed from previous studies the technique of concrete scenarios²¹ and incorporated into them information about current legislation. In half of the cases depicted in scenarios, patients were nationals from a country where PAS is legal (namely the Netherlands), and in the other half, they were nationals from a country where it is illegal (namely France). To what extent do people take into account current laws at the time of judging acceptability in concrete cases? Do people usually harbouring the never acceptable position change their minds for the case of patients living in one of the few countries where PAS is legal? In other words, was their personal position a strictly legalistic one? Symmetrically, was the personal position of people who usually consider PAS acceptable a position that just reflected disdain for the law?

Methods

Participants

The participants were unpaid volunteers living in the area of Toulouse, France. The lay participants were approached by one of six research

assistants while they were walking along the main streets, and the health professionals were contacted at the public hospitals where they worked. Of the 400 lay people and 200 health professionals contacted, 55% of the lay people (221) and 50% of the health professionals (101) gave their informed consent. The demographic characteristics of the sample are shown in Table 1.

Material

The material consisted of 24 vignettes that were composed according to a four within-subject factor design: Patient's country of residence (the Netherlands or France) x Patient's age (80 years or 50 years) x Another physician's advice (yes or no) x Patient's request for a life-ending procedure (no request, some form of request, or repeated formal requests), $2 \times 2 \times 2 \times 3$. The question was, 'To what extent do you believe that the physician's behaviour was acceptable in this case?' The response scale was a 15-point scale with anchors of 'Not acceptable at all' (0) and 'Completely acceptable' (15). Participants were presented with the vignettes in random order.

Procedure

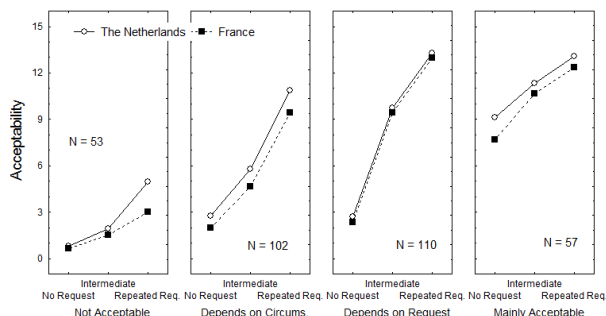
The site for the lay people was either a vacant classroom in the local university or the participant's private home; and for the health professionals, a vacant room in the hospital. Each person was tested individually according to the procedure used in previous studies. The research assistant explained to the participants what was expected, i.e., that for each scenario they were to indicate the degree of acceptability of a decision to resort to PAS. They made ratings at their own pace, and the research assistant made certain that the participants understood all relevant information before they made ratings. The participants took 15-30 minutes to complete both phases. The research adhered to the legal requirements of the study country: informed consent was obtained and participants' anonymity was respected.

Results

A cluster analysis was performed on the raw data in accordance with the recommendations of Hofmans and Mullet.²² Four clusters of participants were identified. They are shown in Figure 1. Their composition in terms of demographic characteristics is shown in Table 1. The results of analyses of variance (ANOVAs) on each cluster are reported in Appendix A.

The first cluster ($N = 53$) was labelled *Not Acceptable* since the ratings were systematically low ($M = 2.15$ on the scale of 0 to 15). Even in the 'best case' – the Netherlands, 80 years, another physician consulted, and repeated request

Figure 1. Judged level of acceptability of PAS as a function of patient's request and country in each of the four clusters. Results were pooled across factors of the patient's age and the consultation of another physician



– the mean rating was 6.74. The ANOVA performed on this cluster showed that the effect of the country, although weak, was significant.

The second cluster ($N = 102$) was labelled *Depending on Circumstances*. The mean rating was 5.91. As shown in Figure 1 (second panel from the left), the ratings clearly depended on the patient's request (the curves are extremely steep) and, to a much lesser extent, on country (the curves are separated but close together). In addition, when another physician had been consulted, the ratings were higher overall and the effect of patient's request was stronger.

The third cluster ($N = 110$), was labelled *Mainly Depending on Request* (see Figure 1, third panel from the left). The mean rating was 8.41. As in the second cluster, the ratings clearly depended on the patient's request (the curves are extremely steep), but they did not depend on country. They were also slightly higher when another physician had been consulted.

The fourth cluster ($N = 57$) was labelled *Mainly Acceptable* since the ratings were systematically high ($M = 10.70$). Even in the 'worst case' – France, 50 years, another physician not consulted, and no request – the mean rating was 7.26. The effect of the country, although weak, was significant.

For each participant, a difference was computed by subtracting the mean response given to the scenarios in which the patient resided in the Netherlands and those given when the patient resided in France. For 50% of the participants, there was essentially no difference, and for 25%, the difference was about one point, that is, very small. For 25% of participants, the difference was higher than 1.5 points, and for 5% it was even higher than 3.5 points. Lay people tended to be found more frequently (72%) in the no-difference category than health professionals (65%) but the difference was not significant.

Table 1. Demographic Composition of the Sample. Composition of the four Clusters. The figures in parenthesis are percentages, except for age

Characteristic	Clusters				Total
	Not Acceptable	Depends on Circumstances	Depends on Request	Mainly Acceptable	
Gender					
Male	18 (15)	38 (31)	45 (37)	20 (17)	121
Female	35 (17)	64 (32)	65 (32)	37 (18)	201
Educational Level					
Primary	3 (5)	24 (37)	25 (38)	13 (20)	65
Secondary	12 (12)	26 (26)	35 (36)	26 (26)	99
University	38 (24)	52 (33)	50 (32)	18 (11)	158
Religious Belief					
Non Believer	21 (13)	54 (33)	62 (38)	25 (15)	162
Believer	26 (23)	32 (28)	33 (29)	23 (20)	114
Regular Attendee	6 (13)	16 (35)	15 (33)	9 (20)	46
Occupation					
Lay Person	24 (11)	67 (30)	84 (38)	46 (21)	221
Nurses' Aide	5 (14)	12 (34)	12 (34)	6 (17)	35
Nurse	14 (33)	17 (40)	8 (19)	4 (9)	43
Psychologist	2 (33)	1 (17)	3 (50)	0 (0)	6
Physician	8 (47)	5 (29)	3 (18)	1 (6)	17
Mean Age	34	41	38	38	37
Total	53 (16)	102 (32)	109 (34)	57 (18)	322

Discussion

Regarding PAS, 75% of participants formulated their acceptability judgments in a way that was largely independent of current laws. People who usually find it unacceptable did not change their position to any significant extent when told that the current legislation in the patients' country allowed PAS. Their opposition to PAS was thus not based on a strict respect for law: they clearly distinguished the domains of law and morality. By contrast, the participants who usually find PAS acceptable, at least under certain circumstances, did not completely ignore law. But they considered law as just another circumstance, and it was not given priority over other determinants such as patient's request and consultation with another physician. Their positive views regarding PAS were thus not due to ignorance of law or to systematic disrespect for it. They also clearly distinguished, in their way, the domains of law and morality. Since laws regarding end-of-life decision-making differ greatly from one country to another in Europe, it is not surprising that the law has less impact than morality on people's views about PAS.

Furthermore, most participants agreed with the laws regulating legalized PAS in emphasizing the particular circumstances that determine acceptability, but they differed in the way they combined these criteria. In the Netherlands, the requirement includes terminal illness, severe suffering, request by the patient for assistance in dying, and the advice of another physician.¹ PAS is either acceptable or not, and all these criteria must be fulfilled to make it acceptable. By contrast, our participants felt that PAS was more or less acceptable and that

its acceptability increased as each of several criteria were met. Unlike the law, their morality was situational and layered, not absolutist.

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Appendix A

A first ANOVA was performed on the data from the first cluster. The design was the one indicated above. PAS was judged more acceptable (a) if patients resided in the Netherlands ($M = 2.56$) than if they resided in France ($M = 1.74$), $F(1, 52) = 25.53$, $p < .001$, (b) when another physician has been consulted ($M = 3.05$) than when another physician has not been consulted ($M = 1.26$), $F(1, 52) = 45.90$, $p < .001$, and (c) when the request was present and repetitive than when it was not, $F(2, 104) = 58.70$, $p < .001$. Post-hoc analyses using the Tukey honestly significant difference test showed that the mean acceptability value observed when the request was present and repetitive ($M = 3.98$) differed significantly from the mean values observed in both other cases ($M = 1.24$), $p < .001$. The Country x Physician interaction was significant, $F(1, 52) = 12.62$, $p < .001$. When patients lived in the Netherlands, the other physician's effect was

stronger (a difference of 2.21 between the highest and lowest mean ratings) than when patients lived in France (a difference of 1.38). The Country x Request interaction was significant, $F(2, 104) = 23.21, p < .001$. When patients lived in the Netherlands, the effect of the request factor was stronger (a difference of 4.14) than when patients lived in France. Finally, the Physician x Request interaction was significant, $F(2, 104) = 26.40, p < .001$. When another physician was consulted the effect of the request factor was stronger (a difference of 4.87) than when another physician was not consulted (a difference of 1.63).

A second ANOVA was performed on the data from the second cluster. PAS was judged more acceptable (a) if patients resided in the Netherlands ($M = 6.45$) than if they resided in France ($M = 5.36$), $F(1, 101) = 31.29, p < .001$, (b) when they were aged 85 years ($M = 6.35$) than 50 years ($M = 5.47$), $F(1, 101) = 26.03, p < .001$, (c) when another physician has been consulted ($M = 7.32$) than when another physician has not been consulted ($M = 4.49$), $F(1, 101) = 135.66, p < .001$, and (d) when the request was present and repetitive than when it was not, $F(2, 202) = 355.59, p < .001$. Post-hoc analyses using the Tukey honestly significant difference test showed that the mean acceptability value observed when the request was present but not repetitive ($M = 5.21$) differed significantly from the mean values observed when the request was repetitive ($M = 10.15$) and when the request was absent ($M = 2.37$), $p < .001$. The Physician x Request interaction was significant, $F(2, 202) = 39.60, p < .001$. When another physician was consulted the effect of the request factor was stronger (a difference of 9.15 between the highest and lowest mean ratings) than when another physician was not consulted (a difference of 6.41).

A third ANOVA was performed on the data from the third cluster. PAS was judged more acceptable (a) when patients were aged 85 years ($M = 8.66$) than 50 years ($M = 8.16$), $F(1, 109) = 13.95, p < .001$, (b) when another physician has been consulted ($M = 9.38$) than when another physician has not been consulted ($M = 7.44$), $F(1, 109) = 177.15, p < .001$, and (c) when the request was present and repetitive than when it was not, $F(2, 218) = 1,117.13, p < .001$. Post-hoc analyses using the Tukey honestly significant difference test showed that the mean acceptability value observed when the request was present but not repetitive ($M = 9.59$) differed significantly from the mean values observed when the request was repetitive ($M = 13.13$) and when the request was absent ($M = 2.52$), $p < .001$. The Physician x Request interaction was significant, $F(2, 218) = 12.40, p < .001$. When another physician was consulted the effect of the request factor was stronger (a difference of 10.93) than when another physician was not consulted (a difference of 10.29).

A fourth ANOVA was performed on the data from the fourth cluster. PAS was judged more acceptable (a) if patients resided in the Netherlands ($M = 11.16$) than if they resided in France ($M = 10.24$), $F(1, 56) = 21.87, p < .001$, (b) when they were aged 85 years ($M = 11.09$) than 50 years ($M = 10.30$), $F(1, 56) = 12.84, p < .001$, (c) when another physician has been consulted ($M = 11.38$) than when another physician has not been consulted ($M = 10.02$), $F(1, 56) = 36.46, p < .001$,

and (d) when the request was present and repetitive than when it was not, $F(2, 112) = 119.61$, $p < .001$. Post-hoc analyses using the Tukey honestly significant difference test showed that the mean acceptability value observed when the request was present but not repetitive ($M = 10.98$) differed significantly from the mean values observed when the request was repetitive ($M = 12.71$) and when the request was absent ($M = 8.40$), $p < .001$.

A global ANOVA was, finally, performed on the whole set of data. Overall, PAS was judged more acceptable (a) if patients resided in the Netherlands ($M = 7.37$) than if they resided in France ($M = 6.60$), $F(1, 320) = 79.97$, $p < .001$, (b) when they were aged 85 years ($M = 7.32$) than 50 years ($M = 6.65$), $F(1, 320) = 79.97$, $p < .001$, and (c) when another physician has been consulted ($M = 8.04$) than when another physician has not been consulted ($M = 5.94$), $F(1, 320) = 349.39$, $p < .001$. The request factor was also significant, $F(2, 640) = 770.53$, $p < .001$. When the request was present and repetitive, acceptability was higher than when it was not repetitive or there was no request. Post-hoc analyses showed that the mean acceptability value observed when the request was present but not repetitive ($M = 7.15$) differed significantly from the mean values observed when the request was repetitive ($M = 10.60$) and when the request was absent ($M = 3.21$), $p < .001$.