

Romanian Lay People's and Health Professionals' Views about the Acceptability of Physician-Assisted Suicide*

Punto de vista de los rumanos hacia la aceptabilidad del suicidio asistido por médicos

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DANIELA IULIA TEODORESCU

Jean-Jaurès University, Francia

ORCID: <http://orcid.org/0000-0002-4101-6063>

MARIA TERESA MUÑOZ SASTRE^a

Jean-Jaurès University, Francia

PAUL CLAY SORUM

Albany Medical College, Estados Unidos

ORCID: <http://orcid.org/0000-0003-4009-9343>

RESUMEN

Las condiciones bajo las cuales el suicidio asistido por médicos podría considerarse aceptable han sido estudiadas en una muestra de rumanos adultos. Los participantes (52 profesionales de la salud y 212 personas non-expertas) examinaron una serie de 36 escenarios realísticos compuestos por combinación de cuatro factores: la edad del paciente, el nivel de curación de la enfermedad, el tipo de sufrimiento, y la demanda del paciente. La recorrida de datos tuvo lugar desde Julio, 2015 hasta mayo, 2016. La mayoría de los participantes (85% de los profesionales y 51% de los non-expertos) expresaron su oposición al suicidio asistido cual sean las condiciones. Los factores más importantes para determinar el nivel de aceptabilidad en los otros participantes fueron la demanda de asistencia a morir (32%) y la edad avanzada (18%).

Palabras clave

suicidio asistido por médicos; aceptabilidad; Rumania.

^a Correspondence author. E-mail: mtmunoz@univ-tlse2.fr

ABSTRACT

The conditions under which Physician-Assisted-Suicide (PAS) would be considered as acceptable among Romanians were examined. In July 2015-May 2016, 212 lay people and 52 health professionals judged the acceptability of PAS in 36 realistic vignettes composed of all combinations of four factors: the patient's age, the level of incurability of the illness, the type of suffering, and the patient's request for PAS. A majority of lay people (51%) and health professionals (85%) were opposed to PAS, quite irrespective of conditions. The most important factors determining acceptability were, for 36% of lay people, request for PAS and, for 18%, advanced age.

Keywords

physician-assisted suicide; acceptability; Romania.

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Legislation has been passed to permit and regulate physician-assisted suicide (PAS) in Belgium, Canada, Germany, Luxembourg, Japan, the Netherlands, Switzerland, and six US states: California, Colorado, Montana, Oregon, Vermont, and Washington (McDougall & Gorman, 2008; Steck, Egger, Maessen, Reisch, & Zwahlen, 2013; *State-by-State Guide to Physician-Assisted Suicide*, 2015). Similar legislation has been under discussion in other U.S. states (e.g., New Mexico, Richardson, 2015), in Western Europe (e.g., France, Heneghan, 2013), and elsewhere in the world (e.g., India, Khan & Tadros, 2013). It is essential, therefore, for policy makers, and health caregivers around the world to appreciate the conditions under which PAS is considered as acceptable or unacceptable to the public.

Empirical research on end-of life decisions has shown huge variations in the impact of these circumstances on lay people's and health professional's level of acceptance of PAS from one country to another (Mullet et al., 2016). In Kuwait, the majority position is that PAS is never acceptable, irrespective of circumstances (Ahmed, Sorum, & Mullet, 2010). In India, the patient's age is the main determinant of acceptability: The older the patient, the higher the acceptability level (Kamble, Sorum, & Mullet, 2011). In Togo, the patient's age has not such impact, but the level of curability of the illness plays an important role (Mullet et al., 2016). In France, the majority position is that PAS is acceptable each time patients clearly and repeatedly request it, irrespective of their age and of the type of suffering (physical pain or complete dependence) (Frileux, Muñoz Sastre, Antonini, Mullet, & Sorum, 2004; Mullet et al., 2014). Health caregivers' acceptability ratings are usually lower than lay people's ratings (Teisseyre Mullet, & Sorum, 2005; Kpanake, Dassa, Sorum, & Mullet, 2014).

The present study was conducted in the Eastern European country of Romania. No study to date has examined the conditions under which PAS is considered as acceptable among East Europeans. The only statistics available

come from a comparative study in which participants from 47 European countries were asked in 2008: "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"? (Cohen, van Landeghem, Carpentier, & Deliens, 2014, p. 144). For Romania, the mean rating was 3.20 on a 1-10 scale, indicating a low level of acceptance. By comparison, the mean rating in Belgium, a country in which PAS is legal was 6.75.

Although this overall rating was low, we expected, in light of previous studies (Mullet et al., 2016), to find several qualitatively different positions: (a) a plurality view that PAS is never acceptable or not very acceptable, and (b) several minority views similar to the ones already found in other studies (never acceptable, not very acceptable, depends on patient's request, depends on curability, quite always acceptable). We also expected that health professionals would, more often than lay people express the opinion that PAS is never acceptable.

Method

Participants

The participants were unpaid volunteers living in the towns of Bucharest, Curtea de Arges, Cluj-Napoca, Iasi, Pitesti, and Sibiu and in the rural areas around these towns. The lay participants were approached by one of the authors while they were walking along the main sidewalks, and the health professionals were contacted at the public hospitals and private clinics or offices where they worked. Forty-two percent of the lay people ($N=212$) and 52% of the health professionals ($N=52$) who were contacted agreed to participate and gave their informed consent. Four lawyers also agreed to participate. The mean age of the 258 participants was 43.39 years ($SD=15.77$, range=18-79). Demographic characteristics are shown in Table 1.

Material

The material consisted of 36 cards containing a vignette of a few lines, a question, and a response scale. The vignettes were composed according to a four within-subject factor design: Type of Suffering (extreme physical pain or complete dependence) x Level of Curability of the Illness (completely incurable vs. extremely difficult to cure) x Patient's Request for a life-ending procedure (no request, some form of request, or repeated formal requests) x Patient's Age (35, 60, or 85 years), 2x2x3x3. The question was, "To what extent do you believe that physician-assisted suicide would be an acceptable procedure in this case?" The response scale was a 15-point scale with anchors of "Not acceptable at all" and "Completely acceptable."

Procedure

The site was for the lay people a vacant room at the local university or the participant's private home; and for the health professionals, a vacant room in the hospital or their office. Each person was tested individually according to the procedure used in previous studies (Anderson, 2008; 2016). The experimenter 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 experimenter made certain that the participants understood all relevant information before they made ratings. PAS was explained in a way that clearly distinguished it from other forms of life-ending procedures like euthanasia or withdrawal of life support. The participants took 15-30 minutes to complete both phases.

The (deleted) does not require approval of a study that involves only questionnaires and is conducted in conformance to the ethical recommendations of the French Society of Psychology. Participants' anonymity was respected and informed consent was obtained. Data gathering lasted from July 2015 to May 2016.

Results

To look for groupings of participants, a cluster analysis was performed on the raw data (Hofmans & Mullet, 2013). Seven clusters of participants were identified. They are described in Table 1 and five of them are shown in Figure 1. Separate ANOVAs were conducted on each cluster with a Suffering x Curability x Request x Age, 2x2x3x3 design.

Table 1
Demographic characteristics of the sample and of each cluster

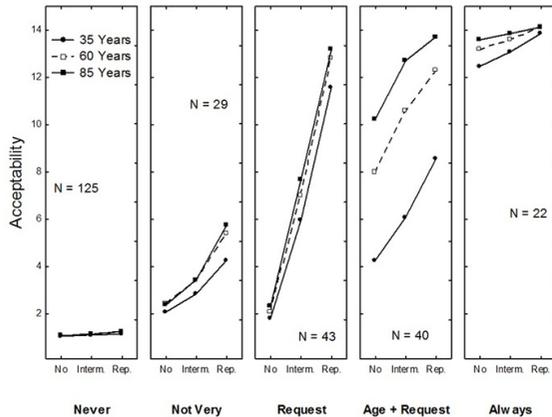
Variables	Clusters							Total
	Never	Not Very	Request	Age + Request	Always	Curabil.	Undeter.	
<i>Gender</i>								
Male	44 (39) ^a	12 (10)	25 (22) ^a	16 (14)	13 (11)	2 (2)	2 (2)	114
Female	81 (52) ^a	17 (11)	18 (12) ^a	24 (15)	9 (6)	4 (3)	1 (1)	154
<i>Age</i>								
18-27 Years	13 (24) ^{abcd}	5 (9)	12 (22)	18 (34) ^{abcd}	6 (11)	0 (0)	0 (0)	54
28-37 Years	24 (45) ^a	5 (10)	8 (15)	7 (13) ^a	5 (9)	2 (4)	2 (4)	53
38-48 Years	29 (54) ^b	4 (7)	10 (19)	7 (13) ^b	2 (4)	2 (4)	0 (0)	54
49-59 Years	26 (49) ^c	5 (9)	7 (13)	4 (8) ^c	8 (15)	2 (4)	1 (2)	53
60-79 Years	33 (61) ^d	10 (19)	6 (11)	4 (7) ^d	1 (2)	0 (0)	0 (0)	54
<i>Milieu</i>								
Rural	51 (43)	14 (12)	22 (18)	19 (16)	7 (6)	4 (3)	2 (2)	119
Urban	74 (50)	15 (10)	21 (14)	21 (14)	15 (10)	2 (1)	1 (1)	149
<i>Status</i>								
Single	18 (37) ^a	3 (6)	9 (19)	10 (21)	7 (15)	0 (0)	1 (2)	48
Cohabitation	7 (22) ^b	5 (16)	8 (25)	11 (34)	1 (3)	0 (0)	0 (0)	32
Married	85 (56) ^{ab}	15 (10)	19 (12)	17 (11)	12 (8)	3 (2)	2 (1)	153
Divorced	8 (42)	2 (11)	4 (21)	1 (5)	1 (5)	3 (16)	0 (0)	19
Widowed	7 (44)	4 (25)	3 (19)	1 (6)	1 (6)	0 (0)	0 (0)	16
<i>Religious Involvement</i>								
Atheists	14 (61)	0 (0)	2 (9)	4 (17)	2 (9)	1 (4)	0 (0)	23
Believers	60 (41)	18 (12)	23 (16)	23 (15)	17 (11)	4 (3)	3 (2)	148
Regular Attendees	51 (53)	11 (11)	18 (19)	13 (13)	3 (3)	1 (1)	0 (0)	97
<i>Group</i>								
Lay People	85 (40) ^{ab}	24 (11)	39 (18) ^a	38 (18) ^{ab}	20 (10)	4 (2)	2 (1)	212
Nurses	13 (65) ^a	3 (15)	2 (10)	0 (0) ^a	1 (5)	1 (5)	0 (0)	20
Physicians	27 (85) ^a	1 (3)	1 (3) ^a	1 (3) ^b	0 (0)	1 (3)	1 (3)	32
Lawyers	0 (0)	1 (25)	1 (25)	1 (25)	1 (25)	0 (0)	0 (0)	4
<i>Personal Experience with PAS</i>								
No	122 (47)	29 (11)	42 (16)	39 (15)	22 (8)	5 (2)	3 (1)	262
Yes	3 (50)	0 (0)	1 (17)	1 (16)	0 (0)	1 (17)	0 (0)	6
<i>Education (Lay people Only)</i>								
Primary	28 (62) ^{ab}	7 (16)	3 (7) ^a	3 (7) ^a	2 (4)	1 (2)	1 (2)	45
Secondary	30 (39) ^a	8 (10)	12 (16)	15 (20)	8 (11)	2 (3)	1 (1)	76
Tertiary	27 (30) ^b	9 (10)	24 (26) ^a	20 (22) ^a	10 (11)	1 (1)	0 (0)	89
Total	125 (47)	29 (11)	43 (16)	40 (15)	22 (8)	6 (2)	3 (1)	268

Six of the clusters were expected, i.e., were similar to those found in previous studies.

The first (47% of the sample) was the *Never Acceptable* cluster; the ratings were systematically low (M=1.13). The second cluster (11%) was the *Not Very Acceptable* cluster; as shown in Figure 1, the ratings were mostly low but nevertheless significantly higher than in the first cluster (M=3.56). Ratings were slightly higher in cases of repeated request (M=5.14) than in those of no request (M=2.30). The third cluster (16%) was the *Patient's Request* cluster; ratings (M=7.17) were considerably higher in cases of

repeated request ($M=12.54$) than in the cases of intermediate request ($M=6.88$) or no request ($M=2.08$).

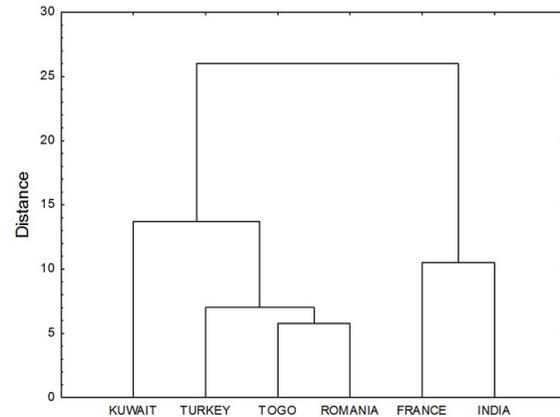
Figure 1.
Patterns of results corresponding to five of the seven clusters



Note. In each panel, the mean acceptability judgments are on the y-axis, the three levels of patient request (No = No request, Intern. = Intermediate request, and Rep. = Repeated request) are on the x-axis, and the three curves correspond to the three levels of patient age. Mean acceptability ratings have been pooled across levels of type of suffering and levels of curability (the least important factors).

The unexpected fourth cluster (15%) was called *Request + Age* ($M=9.61$). Ratings were higher in cases of repeated request ($M = 11.54$) and when the patient was older ($M = 12.22$) than in cases of no request ($M = 7.50$) and when the patient was younger ($M = 6.31$). The effect of request did not vary as a function of patient's age. The fifth cluster was the expected *Quite Always Acceptable* cluster already found in previous studies (8%); the ratings were systematically high ($M=13.54$). The remaining two clusters were much smaller. They were the *Depends on Curability* (2%) and the *Undetermined* (1%) clusters.

Figure 2.
Dendrogram showing the Euclidian distances between the six countries



Detailed Chi-square statistics (see Table 1) showed that (a) females (52 %), older people (52 %), married people (56 %), healthcare professionals (78 %), and less educated people (62 %) were more often in the never acceptable cluster than males (39 %), younger people (24 %), single and cohabiting people (31 %), lay people (40 %), and more educated people (35 %); (b) females (12 %), healthcare professionals (6 %), and people with primary school education only (7 %) were less often in the patient's request cluster than males (22 %), lay people (18 %), and people with tertiary education (26 %); and (c) older people (10 %), healthcare professionals (2 %), and less educated people (7 %) were less often in the request plus age cluster than younger people (34 %), lay people (18 %), and more educated people (21 %).

Figure 2 shows the Euclidian distances between the mean profile of Romanian lay people's ratings and five mean profiles taken from previous studies using the same design (Mullet et al., 2016). The ratings for Romania are closer to the ones observed in Togo and Turkey than in France or India.

Discussion

As expected, several different positions on the acceptability of PAS were found among lay people and healthcare professionals in

Romania, and the dominant position was “never acceptable, irrespective of circumstances”. In addition, a “not very acceptable position”, similar to the one found in Kuwait (Ahmed et al., 2010), was also identified. Taken together, these two positions were endorsed by a majority of the lay people (51%) and by practically all the nurses and physicians (85%). This result was consistent with previous findings on Romanian lay persons' overall opposition to euthanasia (Cohen et al., 2014) and with findings among health professionals conducted in different countries (Kpanake et al., 2014; Teisseyre et al., 2005; Teisseyre, Vanraet, Sorum, & Mullet 2010). In Romania as in other countries, most health professionals may have felt the necessity to conform, in their responses, to current legislation.

The “acceptability depends on patients' request” position, which is one of the most frequent positions found in France, was endorsed by a substantial minority (18%) of lay people. These participants were from the most educated segment of society. A likely greater familiarity with public opinion in Western countries may have influenced their views.

The “request plus age” position, which was endorsed by a similar proportion of lay people (18%), had not been found in previous studies. These participants were also from the most educated (and younger) segment of society. This position is midway between the “acceptability depends on patients' request” position just discussed and the “patient's age” position that was not found here but is the most frequent position in India.⁹ The importance given to the patient's age might be explained not, as in India, by a belief in reincarnation, but by a distinction that is common in many cultures between ‘premature death’ and ‘natural death’ (Fischer, 1993). Assisting an old, suffering patient to die is not an act against nature. The death of a young person is, however, contrary to nature, and assisting it is not permissible.

The limited importance given to the type of suffering and to the level of curability was consistent with previous findings showing that participants in most countries (except Togo,

Kpanake et al., 2014, and to some extent Kuwait, Ahmed et al., 2010) did not consider (a) that people who are completely dependent should be treated differently from those who suffer from physical pain, and (b) that, if the patient is suffering in spite of appropriate treatment, it is irrelevant in considering PAS whether the illness is incurable or very difficult to treat.

The study has, of course, limitations. First, the group of participants was a convenience sample and of only moderate size. Second, the health professionals were contacted at their place of work whereas the lay people were contacted in the streets. It is possible that responding to the scenarios while in the hospital or in the office influenced the health professionals' judgments. Third, the participants responded to vignettes, not to real patients. The use of vignettes, however, is useful—it permits statistical analyses to reveal how people weight and combine separate factors. Fourth, the experimenter did not ask further questions to elucidate the reasons, no doubt both personal and cultural, for the participants' responses.

In summary, Blank and Merrik's (2005) statement that “three-quarters of the world's population is not linked to concepts such as individual autonomy” (p. 204) is applicable to Romania. Any attempt by the government to legalize PAS is likely to be supported by only a minority of lay people and opposed by a majority of health professionals. Yet, as the current generations give way to younger ones, and as people get more educated and turn their eyes to the Western world, support for individual autonomy—and for PAS for suffering patients who request it—is likely to grow stronger.

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Notes

- * Research article.