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ORIGINAL RESEARCH

Role and responsibility of oncologists in assisted suicide. Practice and views among members of the German Society of Haematology and Medical Oncology

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Background: Physician-assisted suicide (PAS) is a controversial practice and regulatory frameworks differ regarding assigned physicians' roles. This study explores clinical experience and views of German oncologists concerning ethically and legally relevant aspects of PAS after change of the law.
Materials and methods: An online survey was conducted among members of the German Society of Haematology and Medical Oncology (DGHO) in March 2021. Descriptive analysis, bivariate and multivariable logistic regression of quantitative data on determinants related to (un)willingness to assist with suicide as well qualitative analysis of free-text comments were carried out.
Results: Seven hundred and forty-five of 3588 DGHO members responded (20.8%). Of these, 29.9% reported requests for a lethal drug and 3.0% ($n = 22$) reported to have assisted with suicide. Almost half of them (47.0%, n = 350) objected to providing PAS, whereas 45.9% indicated a willingness at least under certain conditions. Of those respondents who did not object to PAS, 25.4% would also consider assistance if those willing to die had a psychiatric disease and 10.2% if requestors had no disease at all. A majority viewed a role for physicians regarding different tasks associated with assisted suicide. Respondents with <10 years of professional experience, working in hospital with religious affiliation and with subspecialisation in palliative care were significantly less frequently willing to assist suicide.
Conclusions: Respondents are divided in their personal attitudes towards PAS but a majority supports involvement of physicians regarding different tasks related to assisted suicide. Data about the practice and envisaged professional role may inform development of an acceptable ethico-legal framework for a controversial practice.
Key words: assisted suicide, Germany, haematology, medical oncology, ethics

INTRODUCTION

Whether or not physicians should assist in suicide remains controversial.[1-3] An increasing number of countries and states have issued regulations, which allow physicians to assist patients who wish to end their lives. However, the prerequisites to grant requests for assisted suicide and further practical matters differ considerably between existing regulatory frameworks.[4-6] These differences affect the role of physicians and their assigned tasks with regard to assisted suicide.

The topic of physician-assisted suicide (PAS) and related regulations is of practical relevance for oncologists. Empirical research indicates that patients with cancer form the largest group of increasing proportion of people who are dying by means of PAS.[7-9] In addition, surveys among oncologists indicate that a considerable number of them have been approached by their patients regarding the topic.[10,11] Evaluating such requests by cancer patients poses difficult challenges also in light of the fact that the wish to die of patients with cancer may result from a depression.[12]

The question of how to regulate the practice of assisted suicide is urgent in Germany after the ban of PAS, enacted in law in 2015, was declared unconstitutional in February 2020 by the Federal Constitutional Court.[13] In contrast to,

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for example, the jurisdiction of Oregon,[14] the German Federal Constitutional Court justifies assisted suicide in reference to autonomy only, whereas the extent of a patient's suffering or a terminal diagnosis is not relevant for a valid request. Consequently, assessment of the person's autonomous decision is of paramount importance in determining eligibility for assisted suicide.[15] More recently, different proposals for new legislation have been published.[16-19] In addition, the German Medical Association withdrew the general ban on PAS, which had been included as part of the model Professional Code in May in 2011.

Given the relevance and complexity of (requests for) assisted suicide for oncologists and the current developments regarding its regulation in Germany, the German Society of Haematology and Medical Oncology (DGHO) conducted a survey on the topic among its members in March 2021 with a particular focus on the (potential) role of oncologists in assisted suicide. The study is a follow-up with a number of similar questions of a first DGHO survey on the topic which had been conducted in 2015 before legislating the former ban of assisted suicide.[10]

The aims of this study are:

1. to describe the current experience and practice of oncologists related to requests for PAS;
2. to explore personal attitudes and views of the (possible) roles of and regulations of PAS; and
3. to analyse determinants regarding personal attitudes, practices and views on assisted suicide and to compare present findings with data of the 2015 survey.

MATERIALS AND METHODS

Questionnaire

The questionnaire consists of 52 items related to (requests for) assisted suicide, personal attitudes and views regarding regulations pertaining to and the role of physicians. Eleven items refer to sociodemographic data (see Supplementary Material, available at https://doi.org/10.1016/j.esmoop.2021.100329). The instrument was developed by experts from oncology, health research, palliative care and medical ethics based on previous surveys[10,20-23] and in relation to the content of the different proposals to regulate assisted suicide.[4,16-19] The format of the questions encompasses single and multiple-choice answers as well as options for free text. Two preliminary versions of the survey were pretested by (student) researchers with backgrounds in medicine, ethics, nursing, health research and other subjects.

Data collection and analysis

The online survey together with a short invitation email was sent to all members of the DGHO with a valid email address on 11 March 2021, followed by two reminders. The survey was closed on 31 March. In order to allow all members of the DGHO to participate, we decided against drawing a random sample. In light of limited financial resources for the study, no specific measures such as mixed-mode invitation of participants or use of incentives had been used.

Data were collected anonymously by means of the online platform SurveyMonkey®. The study received an exempt voting from the research ethics commission of the Medical Faculty of the Martin Luther University Halle-Wittenberg (Reg. No. 2021-054).

The results of the descriptive analysis are provided as total numbers and percentages for either the whole sample (including missings) or in the case of filter questions of all participants eligible to respond to the respective question. Answers provided in the annotation free-text fields for each question were coded independently by two researchers (LK, MC) on the basis of structured qualitative content analysis grounded in hermeneutics.[24] Both researchers have expertise in medicine, one is male and one is female. One-third of the data was inductively coded followed by a session to develop a consented, data-derived coding scheme. Conflicts regarding analysis were discussed with the first author (JS) and final decision on coding were made jointly. The remaining data were then analysed with the coding scheme with the possibility to further add subcodes, if necessary. Some codes could not be further grouped and were therefore assigned to a separate collective category. Since there was a lack of depth to the data, we opted for a reporting in absolute frequencies.

Based on published data and drawing from expertise of the multidisciplinary study group, we formulated the following hypotheses:

1. respondents with $<$10 years of professional experience objected more frequently against assisted suicide
2. respondents who worked in a hospital with religious affiliation objected more frequently against assisted suicide
3. respondents with a specialisation in palliative care objected more frequently against assisted suicide
4. respondents who reported requests for prescribing drugs were more often willing to assist in suicide
5. female respondents more frequently requested involvement of more disciplines as part of counselling requestors for assisted suicide.

Binary logistic regression was used to explore bivariate relationships between the dependent variables and independent variables for hypotheses 1-4. Odds ratios (ORs), their 95% confidence intervals (CIs) and P values were computed. For hypothesis 5, answers on the ordinal-scaled questions 'How important is this discipline?' (palliative care, psychology, psychiatry, social work, nursing, nonprofessionals, discipline associated with the underlying disease, other) were considered. A new variable was computed counting the answers 'very important' and 'important' on each subquestion, resulting in an interval variable 'number of involved disciplines'. Hypothesis 5 was then tested via unpaired t-test and results were reported via mean difference (MD), CI and P values. Subsequently, a multivariable logistic regression was carried out with the relevant predictors of hypotheses 1-4 on the willingness to

Table 1. Sociodemographic characteristics

	Respondents n (%)	DGHO members overall n (%)
Gender		
Female	272 (36.5)	1309 (35.7)
Male	420 (56.4)	2.360 (54.3)
Diverse	4 (0.5)	Not available
Missing	49 (6.6)	—
Age, years		
<30	18 (2.4)	59 (1.6)
30-40	92 (12.4)	501 (13.7)
41-50	166 (22.3)	823 (22.4)
51-60	245 (32.9)	958 (26.1)
>60	172 (23.1)	685 (18.7)
Missing	53 (7.1)	559 (15.6)
Workplace		
Outpatient	277 (37.2)	881 (24.0)
Inpatient	458 (61.5)	1.964 (53.5)
University hospital	207 (27.8)	Not available
Other hospital	251 (33.7)	Not available
Other	61 (8.2)	824 (22.5)
Missing	43 (5.8)	—
Specialisation palliative care		
Yes	344 (46.2)	909 (24.8)
No	356 (47.8)	2760 (75.2)

DGHO, German Society of Haematology and Medical Oncology.

assist in suicide in one block using the enter method. P values <0.05 were considered significant. Statistical analysis was carried out with IBM SPSS Statistics version 24.0 for Windows (Armonk, NY).

RESULTS

In total, 745 of 3588 DGHO members with a valid email address responded to the survey (20.8% response rate). Of these, 36.5% (n = 272) were female, 80.4% (n = 599) had worked for at least 10 years in oncology and 344 respondents (46.2%) had an additional specialisation in palliative care. Table 1 summarizes the sociodemographic characteristics of respondents and of all DGHO members.

Requests for assisted suicide

Of the respondents, 29.9% (n = 223) had experienced requests from cancer patients for a prescription for drugs to commit suicide. Frequencies of requests for prescriptions reported ranged from 1 to >100 times within a professional lifetime. Most of these requests (n = 170; 76.2%) came from patients in a palliative situation without options for further specific cancer treatment (see Figure 1).

Assistance with suicide

A proportion of 22 respondents (3.0%) reported having assisted in suicide. Respondents within this group indicated that they had assisted suicide in the range of 1 up to >15 cases (median: 1). Nine respondents reported having prescribed drugs for suicide and six to handing out drugs for this purpose to their patients. Twelve respondents of this group were male and 10 worked in the outpatient setting, whereas 8 worked in hospitals. Eighteen of these respondents indicated >10 years of professional experience.

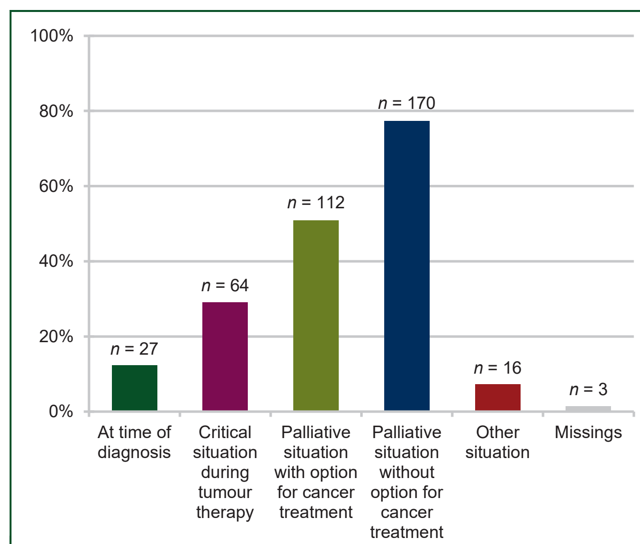

Figure 1. Clinical situations of patients who requested a prescription for drugs for suicide (multiple answers possible).

Personal attitudes and views on professional law

About half (n = 350; 47.0%) of the respondents categorically objected to assist in suicide, whereas 30.3% (n = 226) indicated support under certain conditions and 15.6% (n = 116) reported general support for assisted suicide. The most frequently mentioned comments in free text related to (non-)willingness to assist with suicide were 'symptoms and prognosis' (n = 14), 'statements against assisted suicide' (n = 14) and 'relevance of the legal framework for willingness' (n = 11) as criteria for the individual position. Eight respondents mentioned 'personal knowledge of the requestor and their circumstances' as a further relevant criterion for their willingness to assist with suicide. All codes from free-text analysis with regard to this and further quantitative data presented in this paper are provided in the Supplementary Material, available at https://doi.org/10.1016/j.esmoop.2021.100329.

Respondents who did not exclude willingness to assist with suicide were invited to indicate conditions under which they were willing to consider such assistance. Intractable suffering (n = 329; 83.7%) and decisional capacity (n = 328; 83.5%) were named most frequently as the condition, whereas time to death was viewed as relevant by a minority of participants. Figure 2 illustrates responses to answer options given. About a quarter (n = 96; 25.4%) indicated that they would consider assistance in suicide also if requestors had a psychiatric disease and 10.2% (n = 40) indicated that they would do so if requestors had no disease at all.

A prohibition of assisted suicide by professional law was rejected by 43.5% (n = 324) of respondents, 26.7% (n = 199) supported such professional law and 26.2% (n = 195) were undecided. As part of free-text comments, the 'need for clear regulations' (n = 14), 'individual leeway for physicians' (n = 8) and 'patients' autonomy and right to die' (n = 6) were mentioned most frequently as topics related to the question.

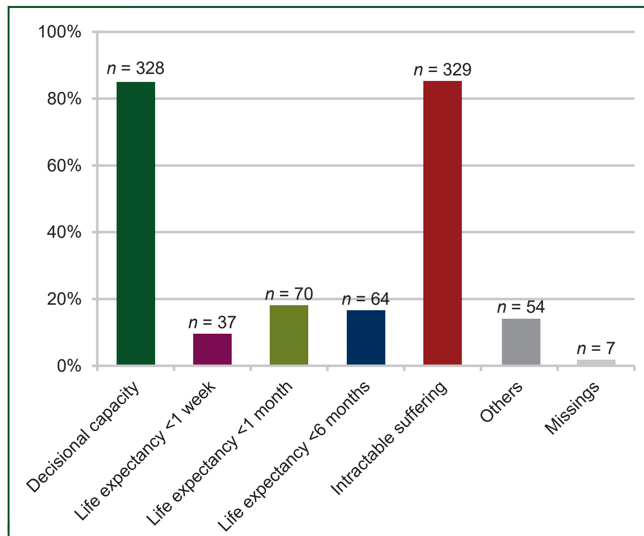

Figure 2. Prerequisites for considering assisted suicide (subgroup of respondents who did not object to assisted suicide; multiple answers possible).

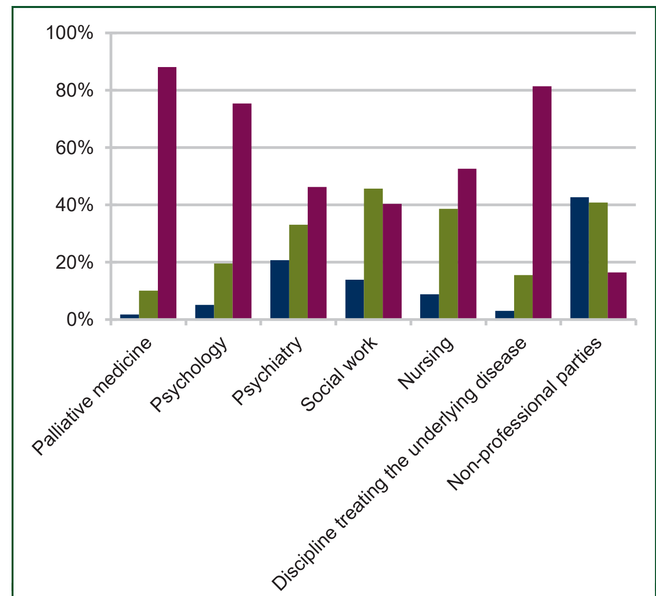

Figure 3. Disciplines and further parties to be involved in case of requests for assisted suicide (multiple answers possible; blue = less important, green = important, red = very important).

Views on the role of physicians in assisted suicide

When asked about the role they would assign to physicians regarding the counselling of people requesting assisted suicide, 43.6% (n = 325) of respondents indicated that this task may be conducted by physicians, and 32.6% (n = 243) indicated that this task should be exclusively carried out by physicians, whereas 10.7% (n = 80) objected to a role of physicians in counselling. Twenty-four respondents emphasised 'multiprofessional teams' as a structural element for counselling, whereas 21 comments referred to the need for the 'involvement of physicians' in counselling in the additional free-text comments. The free-text comments of 15 respondents mentioned 'involvement of a psychologist or psychiatrist' as a further element of the counselling process.

The two most frequently mentioned disciplines that should be involved in counselling were professionals of palliative care (n = 617; 88.1%) and the discipline specialised in the disease of the patient (n = 562; 81.5%). Figure 3 summarizes the frequencies of the parties named who should be involved and priorities according to respondents.

The majority of respondents saw a role for physicians in assessing whether requests are an expression of decisional capacity: 43.0% (n = 320) of the respondents indicated that an assessment of whether the requestor has the decisional capacity for decision making may be conducted by physicians and 25.9% (n = 193) indicated that this task should be carried out exclusively by physicians. 14.5% (n = 108) objected to the participation of physicians regarding this task. The most frequent free-text comments on the assessment of decisional capacity referred to 'multiprofessional (ethical) case discussion' (n = 42), 'involvement of a psychologist or psychiatrist' (n = 20), 'involvement of physicians' (n = 10) and involvement of 'legal professionals' (n = 5).

When it comes to dispensing drugs for assisted suicide, the proportion of respondents who said this task should be exclusively carried out by physicians summed up to 42.0% (n = 313) with an additional 20.1% (n = 150) thinking that it may be carried out by physicians, while 25.0% (n = 186) responded that this task should not be carried out by physicians.

Determinants associated with experiences and views on assisted suicide

Based on bivariate logistic regression, respondents with <10 years of professional experience were less frequently willing to assist in suicide (OR: 0.41; CI 0.26-0.65; P = 0.00) compared to respondents with longer professional experience. Similarly, respondents who worked in a hospital with religious affiliation (OR: 0.54; CI 0.33-0.89; P = 0.014) and respondents with a subspecialisation in palliative care less frequently considered assistance in suicide (OR: 0.74; CI: 0.55-0.99; P = 0.047). There was no difference with regard to willingness to assist in suicide in respondents who had been approached for prescribing lethal drugs compared to those who had not reported such practice experience (OR: 1.14; CI 0.82-1.54; P = 0.465). Female respondents voted for involvement of more disciplines and further parties in counselling compared to male respondents (MD: 0.32; CI 0.10-0.53; P = 0.005). Multivariable logistic regression on willingness to assist with suicide and predictors' subspecialisation in palliative care, religious affiliation and <10 years of professional experience yielded a relevant model (P = 0.00) with a Nagelkerke's R^2 of 0.042. However, only religious affiliation (OR: 0.55; CI 0.33-0.91; P = 0.20) and professional experience (OR: 0.42; CI 0.26-0.67; P = 0.00) showed meaningful contribution to the model.

Comparison with 2015 DGHO survey

Compared with the data of our survey on the topic in 2015 among DGHO members, there was less willingness to assist in suicide (OR: 0.59; CI 0.48-0.73; P = 0.00), less requests for

lethal drugs (OR: 0.33; CI 0.26-0.43; $P = 0.00$) and more support for prohibition of assisted suicide by professional law (OR: 1.85; CI 1.489-2.31; $P = 0.00$) 6 years ago than in 2021.

DISCUSSION

This study presents up-to-date and detailed data of a large German oncologist cohort on self-reported practices, personal attitudes and views regarding the regulation of assisted suicide. The main findings of this study are, firstly, only a small proportion of oncologists (3.0%) have assisted in suicide but a considerable number of participants (29.9%) had been confronted with requests for a drug prescription for the purpose of assisted suicide. Secondly, respondents' attitudes were heterogeneous regarding their (un)willingness to assist in suicide. Only a minority (26.7%) supported a prohibition of assisted suicide by means of professional law. Decisional capacity and intractable suffering were important criteria for those willing to assist with suicide. Thirdly, a majority of respondents viewed involvement of physicians as a possible or even obligatory task for physicians in the context of assisted suicide. Finally, we could identify <10 years of professional experience, religious affiliation of the workplace and additional qualification in palliative care as factors associated with objecting to assisting with suicide. In addition, there were significantly less experienced requests and more support for prohibition of assisted suicide in our 2015 survey compared with the data of this present study.

Practices regarding (requests for) assisted suicide

Almost one-third of respondents had been approached at least once by patients for a prescription for lethal drugs. This is less than the 50.6% of requests for assisted suicide reported in a study among US oncologists,[11] but the difference may be explained by the fact that participants in our survey were asked specifically about prescription of lethal drugs. In the preceding study among German oncologists in 2015, only 13% indicated that they had been asked for a prescription for a lethal drug.[10] Since most requests reported are triggered in the last phase of cancer care, it is important to explore whether and how far these requests could be influenced with even better palliative support and which additional professional competences are needed to handle these difficult situations.[25] Existing guidance points to a broad range of factors necessary to consider in these situations, including ethical and communication competences.[26]

Three percent of respondents had assisted in suicide with a range of frequency of 1 to >15 times during their professional lifetime. These figures are comparable to data of a more recently published survey among US geriatricians according to which 2.2% reported prescription of drugs for suicide[21] and corresponds with our own survey from 2015.[10] While the figures appear to be small, available data from Switzerland and Oregon indicate that there is a trend towards increasing reporting rates of assisted suicide during recent years.[9,27] From an organisational perspective, this means that it is necessary as part of the regulation which allows assistance of suicide to clarify how the relatively rare requests for assisted suicide can be dealt with by physicians and/or other professionals who are willing and competent to participate in the evaluation of such requests.[28]

Personal attitudes and views on the regulation of practice

Similar to other surveys published in recent years,[20,21,29-31] respondents are divided about their (un)willingness to assist in suicide. Interestingly, there are considerably fewer respondents supporting the prohibition of assisted suicide by professional law compared with rejecting it on the level of personal attitudes. In a most recent survey among UK physicians which was conducted by the British Medical Association in 2020, a similar picture could be documented. Forty-five percent of survey participants were not willing to prescribe life-ending drugs, whereas 36% would do so. In addition, 33% of members of the British Medical Association supported a professional stance by the association against assisted suicide.[32] In comparison with findings of our 2015 survey among members of the DGHO, there is a significant decrease of support for prohibition by professional law. One explanation for less support of prohibition of PAS by professional law in our study may be the experiences with the professional ban since 2011 and the controversial debate about an adequate ethical and legal framework for PAS during recent years in Germany.

The refusal of assisted suicide by a large proportion of physicians showed in this and other surveys points to the need to establish regulations and frameworks which ensure that constellations in which a request for assisted suicide meets a refusing physician can be dealt with in a way that on the one hand respects patients' autonomy and at the same time pays respect to personal values of physicians. A further point which, based on our findings, we deem relevant for the acceptance of any normative framework to guide practice are certain criteria as perquisites for allowing assisted suicide. As reported only 10.2% were willing to assist in suicide in the case of absence of illness and 83.7% viewed some form of suffering as prerequisite for their willingness to assist with suicide. This stands in contrast to the ruling of the German Constitutional Court which rejects limiting lawful requests to certain diagnoses or prognosis.[13] It is foreseeable that there will be situations in which requests are lawful but in which only a few physicians may be willing to assist due to a lack of perceived suffering. Such conflicts can be observed already in other jurisdictions. In Switzerland, for example, where there is also no legal restriction related to disease and prognosis, professional guidance has been issued which refers to some form of unbearable suffering as prerequisite for assisted suicide.[33]

According to the respondents, a majority viewed at least a possible and in parts even an obligatory role of physicians regarding the tasks relevant to assistance with suicide. Interestingly, respondents were mostly divided concerning

the prescription of lethal drugs. This task was viewed by more respondents as a task which should be carried out by physicians. At the same time, rejection of prescription as a professional task was also higher compared to the rejection of involvement in counselling or assessing capacity.

Determinants of attitudes and views among oncologists

Bivariate analysis indicates that longer professional working years and experience was associated with more frequent willingness to assist with suicide. A possible reason for this may be that confrontation with requests and discussion of underlying reasons during a longer period of practice might trigger in some physicians a change of personal views. In contrast, specialisation in palliative care was associated with significantly less willingness to assist in suicide. On the one hand, this finding may be interpreted against the background of additional professional expertise of respective oncologists who may be more aware of alternative treatment options in the case of intractable suffering, such as deep continuous sedation.[34] On the other hand, the finding may also resemble the normative stance of the palliative care organisations, which have repeatedly advocated against PAS.[35,36] The relevance of religious affiliation for attitudes towards assisted suicide and other end-of-life decisions has been demonstrated in several studies.[20,23,37] Our study adds to this knowledge by indicating that an affiliation to the church on the level of a hospital is also associated with a significantly higher proportion of oncologists objecting to assisted suicide. Given that the request of assisted suicide is posed within the context of palliative care and/or religious institutions, our data suggest that it will be particularly important to clarify how requests in institutions which refuse involvement in assisted suicide can be dealt with in an adequate manner.

Limitations

A limitation of this study is the response rate of 20.8%, which is less than the response rate of the more recent US online surveys among geriatricians[21] or Swedish physicians,[38] comparable to a recent British Medical Association's as well as surveys on Irish consultant physicians[39] and US physicians,[40] but higher than the recent Royal College of Physician's[41,42] or other online surveys among members of the DGHO.[43,44] In this context, it is important to consider unit non-response as a source of non-representative findings. One indicator for relevant selection is the overrepresentation of oncologists with a subspecialisation in palliative care. Accordingly, it may be that our findings represent a group of oncologists particularly interested in the topic. In addition, there are data indicating that physicians in palliative care were more opposed towards assisted suicide.[29] Accordingly, our results might be biased in this respect. As indicated in the Materials and methods section, possible additional strategies for gaining a more representative sample could be used in a next study under the provision of more resources. While the topic of the survey was on assisted suicide, non-physician members of the DGHO were not excluded. However, based on an analysis of the responses, we could identify only one respondent as a non-physician. One further factor possibly limiting the interpretation of findings is the formulation of the questions.[45] We considered this factor as part of the pretest by involving practitioners, researchers and student researchers with different moral stances towards the topic to avoid judgmental language as far as possible. Finally, social expectations and a fear of possible legal consequences may have influenced the answers of respondents even though all potential participants had been informed about anonymous data collection and analysis.

Conclusions

This study provides information about the stance of German oncologists on assisted suicide in times of dynamic changes regarding legal and professional framework on the matter. While the data cannot be generalized due to the non-representative sample, our findings are in line with research showing a divided personal stance within the medical community. In addition, our research provides insights on practices and views which can be used for the pending formulation of regulation and practice guidance. Examples in this respect are the findings that German oncologists rarely assist with suicide, though a larger proportion receives requests for prescribing lethal drugs. In addition and relevant for the acceptance of regulation and guidance, a large proportion of participants view suffering as an important prerequisite for willing to assist with suicide. While only a minority supports prohibition by professional law, there is a heterogeneity of views regarding the appropriate role oncologists should play as part of a regulation that allows citizens to perform assisted suicide. Against this background we conclude that any regulation on professional guidance should take into account the rather detailed information available on practice, views and related challenges to be able to inform a controversial and multifaceted practice which needs to respect autonomy on the one hand and on the other hand must make sure that harm will be avoided.

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DISCLOSURE

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