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Short report

Attitudes towards legalising physician provided euthanasia in Britain: The role of religion over time☆

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ABSTRACT

Hastening the death of another whether through assisted suicide or euthanasia is the subject of intense debate in the UK and elsewhere. In this paper we use a nationally representative survey of public attitudes – the British Social Attitudes survey – to examine changes in attitudes to the legalisation of physician provided euthanasia (PPE) over almost 30 years (1983–2012) and the role of religious beliefs and religiosity in attitudes over time. Compatible questions about attitudes to euthanasia were available in the six years of 1983, 1984, 1989, 1994, 2005, and 2012. We study the trends in the support for legalisation through these time points and the relationship between attitudes, religious denomination and religiosity, controlling for a series of covariates. In total, 8099 individuals provided answers to the question about PPE in the six years of the study. The support for legalisation rose from around 76.95% in 1983 to 83.86% in 2012. This coincided with an increase in secularisation exhibited in the survey: the percentage of people with no religious affiliation increasing from 31% to 45.4% and those who do not attend a religious institution (e.g. church) increasing from 55.7% to 65.03%. The multivariate analysis demonstrates that religious affiliation and religiosity as measured by religious institution attendance frequency are the main contributors to attitudes towards euthanasia, and that the main increase in support happened among the group with least religious affiliation. Other socio-demographic characteristics do not seem to alter these attitudes systematically across the years. Our study demonstrates an increase in the support of euthanasia legalisation in Britain in the last 30 years coincided with increased secularisation. It does not follow, however, that trends in public support are immutable nor that a change in the law would improve on the current pragmatic approach toward hastening death by a physician adopted in England and Wales in terms of the balance between compassion and safeguards against abuse offered.

1. Introduction

Both physician assisted suicide and euthanasia share the common effect of hastening death. In assisted suicide the individual with the assistance of a physician acts to hasten their own death while in euthanasia – with physician involvement – the physician acts to hasten the death of the individual. Assisted suicide has been legalised in five states of the USA (Washington, Oregon, Vermont, New Mexico and Montana) as well as Luxembourg, the Netherlands, Germany, and Switzerland. Euthanasia has been legalised in Belgium (though not mentioned explicitly in legislation), the Netherlands and Luxembourg. Despite its legalisation in several jurisdictions, hastening death, remains the subject of intense debate in these and other jurisdictions (Hendry et al., 2013; Steck et al., 2013) as does interpretation of trends in their rates in those jurisdictions where it has been legalised (Gamondi et al., 2014; Onwuteaka-Philipsen et al., 2012).

In the UK, there is an ongoing debate on the issue of legalising assisted suicide, though less attention is devoted to euthanasia. The current legal position with respect to assisted suicide might be described as pragmatic. In England, Wales, and Northern Ireland, for example, individuals who assist in the death/suicide of another could face prosecution under 1961 Suicide Act. However, in 2010,

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the Director of Public Prosecutions issued guidelines detailing provisions under which a prosecution would not be pursued (Crown Prosecution Service, 2010) in England and Wales. Since 2002 of over 90 cases examined none has resulted in a prosecution in England and Wales (Curtice and Field, 2010). Attempts to provide clarity around the legal position of those assisting others to end their lives through a private member's Bill in the UK's House of Lords in July 2014, provoked intense debate.

A number of studies have demonstrated public support for legalisation of assisted suicide/dying and/or euthanasia across a number of countries including the UK (Albanese, 1996; Caddell and Newton, 1995; Dietz, 1997; McLean and Britton, 1996; Seale and Addington-Hall, 1994, 1995a, 1995b; Wise, 1996; O'Neill et al., 2003). These attitudes vary depending on for whom legal protection is sought – whether family members or physicians (O'Neill et al., 2003) – as well as on whose opinions are sought and on the precise wording of the question posed (Clements, 2014). A body of literature has demonstrated the importance of religious beliefs in attitudes to these subjects both in terms of the strength of the religious affiliation – religiosity (Bachman et al., 1996; Baume et al., 1995; Jorgenson and Neubecker, 1980; Kalish, 1963; O'Neill et al., 2003; Suarez-Almazor et al., 1997; Ward, 1980), and in terms of the religious denomination with which one is affiliated (Anderson and Caddell, 1993; Caddell and Newton, 1995; O'Neill et al., 2003). Interestingly studies have shown that a majority of doctors in the UK oppose legalisation of physician assisted suicide and euthanasia and that their religiosity appears to affect their attitudes (McCormack et al., 2012), a finding echoed elsewhere (Gielen et al., 2009).

Given the recent debate in the UK on legalisation of assisted suicide/dying it is perhaps timely to review public attitudes to the subject. In this paper we use a nationally representative survey of public attitudes in Britain – the British Social Attitudes survey – to examine attitudes to the legalisation of the physician hastening the death. Specifically, we study (i) if these attitudes changed over almost 30 years (1983–2012) and (ii) the role of religious beliefs and religiosity in attitudes and the role of religion and religiosity in attitudes over time.

2. Methods

In this study, we use British Social Attitudes Survey data available since 1983 (National Centre for Social Research, 1983–2012). As our study involved secondary analysis of an anonymised publicly available dataset, no ethical approval was necessary. Compatible questions about attitudes to legalisation of hastening death were available in the years of 1983, 1984, 1989, 1994, 2005, and 2012. The respondents were asked: "Suppose a person has a painful incurable disease. Do you think that doctors should be allowed by law to end the patient's life, if patient requests it?" with the options to answer "yes" or "no", or "don't know". While we interpret the data as reflective of attitudes to euthanasia we concede the possibility of confusion on the part of the respondents with assisted suicide in the responses provided. We study the trends in the support for legalisation of euthanasia through the time points and the relationship between attitudes, religious denomination and religiosity, controlling for a series of covariates identical to those used by O'Neill et al. (2003) in a cross sectional analysis of 1994 data.

Religious denomination was aggregated into five groups, based on the numbers present in the sample: those with no religious affiliation, Roman Catholics, Church of England, other Christians, and non-Christians. The latter group is small though its size has substantially increased in the sample over the study period. We include a proxy factor for the strength of religious beliefs – frequency of church (religious institution) attendance, this being split into groups of frequent users (once a week), less frequent users (less often than once a week), occasional attendants (varies), and those who do not attend religious services or state having no religion. A series of socio-demographic factors were included in the analysis: education, age, sex, household income (quintiles), and marital status. We assume that the attitudes towards euthanasia might be correlated with respondent's satisfaction with the health care system as an indicator of unmet need (Largey and O'Neill, 1996; Seale and Addington-Hall, 1995b), and hence, control for this relation. Again following O'Neill et al. (2003) we sought to capture an individual's autonomy of opinion regarding attitudes to the law by incorporating their stated willingness to ignore a law they disagreed with.

Difference in proportion tests of respondents supporting legalisation in the whole sample and in the sample partitioned by religiosity and religious denomination over time were undertaken; these are presented in the Supplement 1. A series of multivariate logistic regressions for each time point were also undertaken to assess the impact of the covariates on the binary indicator: support for the legalisation of euthanasia in each year. These results are reported in Table 2. To study specifically the presence of an annual trend, adjusted for the effects of other covariates, a pooled logistic regression with the number of years since 1983 as a covariate was also estimated and reported in Table 2. Sampling weighting factors provided in BSAS data were applied in the analyses. Changes to questions across years necessitated changes to the precise format of regression models. Hence, where information on certain characteristics were not available in certain years these were omitted (e.g. education level for 1983 and 1984, satisfaction with NHS for 2012). The level of (dis)obedience to law is proxied by different questions in 1983/84, i.e. "Would you break a law under certain circumstances if you are strongly opposed to it?", and 1989–2012, i.e. "The law should always be obeyed even if one feels that it is wrong/unjust". In the pooled regression, the covariates that were not available for all six years were omitted as they would have been collinear with the year effect if introduced.

3. Results

In the six years of the study, 8099 individuals provided answers to the question about euthanasia: 1640 in 1983, 1541 in 1984, 1288 in 1989, 956 in 1994, 1751 in 2005, and 923 in 2012 (see Table 1). The lowest support is observed in 1983 and 1984, i.e. 76.95% and 75.95% respectively, support growing to 83.86% in

Table 1
Summary statistics.

	1983	1984	1989	1994	2005	2012
Supportive of PAS	**1640**	**1541**	**1288**	**956**	**1751**	**923**
No	23.05%	24.21%	20.96%	16.21%	18.10%	16.14%
Yes	76.95%	75.79%	79.04%	83.79%	81.90%	83.86%
Religiosity (church attendance)	**1747**	**1667**	**2982**	**3455**	**4241**	**3246**
No religion	31.14%	31.73%	5.40%	8.08%	11.04%	16.94%
Never	24.56%	23.58%	48.42%	50.71%	52.82%	48.09%
Once a week	13.17%	12.78%	13.01%	12.50%	9.88%	10.29%
Less often than once	30.62%	31.37%	32.49%	28.25%	25.61%	23.69%
Varies	0.52%	0.54%	0.67%	0.46%	0.66%	0.99%
Religious denomination	**1754**	**1667**	**3024**	**3461**	**4243**	**3229**
No religion	31.01%	31.73%	34.29%	37.99%	39.24%	45.40%
Roman Catholic	9.69%	11.40%	11.11%	9.48%	9.33%	9.01%
Church of England	40.36%	40.73%	37.10%	34.44%	28.40%	23.66%
Other Christian	17.10%	14.46%	15.77%	15.49%	18.74%	17.25%
Non-Christian	1.82%	1.68%	1.72%	2.60%	4.29%	4.68%