Journal of medical ethics 1995; 21: 49–54

Professed religious affiliation and the practice of euthanasia

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Abstract

Attitudes towards active voluntary euthanasia (AVE) and physician-assisted suicide (PAS) among 1,238 doctors on the medical register of New South Wales varied significantly with self-identified religious affiliation. More doctors without formal religious affiliation ('non-theists') were sympathetic to AVE, and acknowledged that they had practised AVE, than were doctors who gave any religious affiliation ('theists'). Of those identifying with a religion, those who reported a Protestant affiliation were intermediate in their attitudes and practices between the agnostic/atheist and the Catholic groups. Catholics recorded attitudes most opposed to AVE, but even so, 18 per cent of Catholic medical respondents who had been so requested, recorded that they had taken active steps to bring about the death of patients.

Introduction

Active voluntary euthanasia (AVE) covers the taking of active steps to hasten the death of another person. It contrasts with passive euthanasia in which specific allopathic treatment (but not good symptomatic care) is withdrawn or not commenced, and with physician-assisted suicide (PAS) in which the means are made available by a practitioner of medicine to someone wishing to end his/her own life.

Most established religions (the Anglican Church of Australia (1), the Roman Catholic Church (2,3), Judaism (4,5,6), Islam (7)), but not yet the Uniting Church in Australia (8), disapprove of AVE and have teachings specifically opposed to euthanasia and to suicide. To learn how the assertions of religious affiliation might be reflected in the practices and attitudes of registered medical practitioners in Australia we undertook this analysis, as part of a wider study on euthanasia, to investigate how, in New South Wales, those professing particular religious affiliations acknowledged that they responded to requests from patients for euthanasia or to other means for hastening death.

Key words

Euthanasia; religion.

Methods

The survey into attitudes and practices of 2,000 practitioners on the medical register of New South Wales has been described elsewhere (9). In answer to one question, 1,238 (97·5 per cent) practitioner respondents indicated their religious affiliation. Because the survey was based closely on one done in Victoria seven years ago to allow comparisons across time and states, there were no questions about the strength of religious affiliation, or about the frequency of religious observance. Answers from anonymous individual questionnaires were cross-tabulated to determine the significance of religious affiliation in answers to a range of specific questions about the practice of euthanasia and suicide and about attitudes of practitioners towards AVE and PAS. Analysis compared the proportions between the groups using Yates-corrected chi-squared statistics. Logistic regression models, using forced entry of independent variables, were developed to assess the likelihood of response to particular statements about euthanasia (10). Likelihood was presented as odds ratios (and their 95 per cent confidence intervals), after adjustment for the potential confounders of age, sex and type of practice of the responding doctors.

Of those who returned completed questionnaires, 20 identified themselves as being 'lapsed' – 15 Catholics, two Anglicans and three Jews. These people had not chosen to identify themselves as agnostic/atheist, although that option had been open to them. For purposes of analysis they were included as belonging still to their religion of birth – so measuring the long-term consequences of childhood and adolescent exposure to particular religious teaching within families. The questionnaire did not distinguish between atheism and agnosticism – a grouping together that was commented upon adversely by some respondents.

Results

After exclusions were made for wrong addresses, deaths, practitioners out of Australia, and for an estimate of the number who failed to receive the questionnaires, the initial sample of 2,000 doctors reduced to 1,656 from which 1,268 answers were

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Table 1

Religious affiliations of 1,238 NSW medical practitioners

		Sample studied		All NSW*
		Number	Percentage	Percentage
Agnostic/atheist		362	29·2	10·0
Christian	Catholic	240	19·4	29·5
	Anglican	230	18·6	27·3
	Other	199	16·1	15·3
	Protestant 'Christian'	22	1·8	N/A
Non-Christian	Jewish	60	4·8	0·5
	Hindu	45	3·6	0
	Buddhist	15	1·2	1·0
	Moslem	11	0·9	1·4
All others		54	4·4	5·8
No answer				9·1
	Total	1238	100	99·9

*NSW population percentages obtained from Australian Bureau of Statistics (14).

received before the cut-off date, giving an overall response rate of 76·6 per cent. If those who had not received the questionnaires were not excluded, the sample reduced only to 1,945 and the response rate became 65·2 per cent.

Self-identified religious affiliations of the 1,238 medical practitioners are shown in Table 1.

While slightly different percentages of those claiming adherence to different religions were found among the various age groups, the differences were slight and not significant. As religious affiliation was related to age group and to type of practice (but not to gender), adjusted analyses are now reported.

Aggregating respondents into two groups – 876 'theists' and 362 'non-theists' we compared the answers of those who professed any religion with those who identified themselves as agnostic or atheist. The differences are set out in Table 2.

Overall, 543 of 1,159 respondents had been asked by patients to hasten death, and 27·9 per cent of these reported that they had taken active steps to hasten death, a figure which is comparable with that reported from Victoria in 1988 (11). Of those identifying as agnostic or atheist who had been asked to hasten death, more than one third (34·6 per cent) recorded that they had taken active steps to comply with such a request at least once, compared to just under a quarter (24·7 per cent) of those who identified a religious affiliation. The 'non-theists' were 1·6 times as likely to practise AVE as were all 'theists'. Only 18 per cent of those who identified themselves as Catholic, 28 per cent of Anglicans, 25 per cent of other Protestants, 22 per cent of other Christians, 35 per cent of Jews and 35 per cent of Moslems had taken active steps to hasten death. Those who classed themselves as 'lapsed' did not behave significantly differently from the rest.

'Non-theists' were more than twice as likely to know of other doctors who practised AVE, and were more than three times more likely to think AVE to be sometimes right, compared to 'theist' practitioners (Table 2). 'Non-theists' were significantly more likely to favour the Dutch arrangements and to indicate support for professional responsibility regarding euthanasia policies and the need for legal changes, compared to all 'theist' doctors (Table 2).

Those identifying with different religions were then analysed separately. Because numbers were small in some groups, the differences did not reach significant levels. Table 3 examined differences within the 'theist' group, comparing Catholics (n=240), Anglicans (n=230), other Protestant (n=199), Jewish (n=60) with agnostic/atheist practitioners.

The table shows that agnostic/atheist practitioners were most sympathetic to the idea of AVE and PAS, with Jewish practitioners sympathetic to almost the same degree. Catholic practitioners were most opposed to AVE and to PAS, while Protestant practitioners fell midway between.

Logistic regression analysis was carried out for three of the questions and compared the likelihood of a *positive* response by practitioners with different religious affiliations compared to agnostics/atheists. The results, shown in Table 4 indicate that all groups of 'theists' are slightly less likely to have been asked to hasten death. This was only significantly different for 'other Protestant' and 'others (including Moslems)'. Only Catholics were significantly less likely to have taken steps to hasten death, with all other groups of 'theists' only slightly less likely compared to the agnostic/atheist reference group to

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Table 2

Differences between 'theists' and 'non-theists' in answer to questions about euthanasia

Question (with number providing answer)	Non-theists percentage	Theists percentage	Adjusted odds ratio (95% CI)#
Have been asked to hasten death (n=1,159)	54	43·9*	1·50 (1·16–1·93)
If asked have practised AVE (n=555)	34·6	24·7*	1·62 (1·09–2·38)
Know other doctors who practise AVE (n=1,173)	68·1	49·3**	2·20 (1·69–2·87)
It is sometimes right to perform AVE (n=121)	77·9	52·6**	3·18 (2·39–4·22)
Attitude based on secular ethical principles (n=1,156)	84·3	57·3**	3·98 (2·89–5·50)
Physician-assisted suicide sometimes right (n=1,212)	77·1	48·4**	3·57 (2·70–4·74)
Should Australia adopt Netherlands arrangements (n=1,215)	78·7	52·1**	3·39 (2·54–4·52)
Professional organisation should have a euthanasia policy (n=1,209)	70·6	45·5**	2·87 (2·20–3·75)
Law should be changed to allow AVE (n=1,218)	76·8	50·6**	3·24 (2·45–4·29)
Law should be changed to allow PAS (n=120)	63	39·4**	2·62 (2·03–3·39)
Would practise AVE if it were legal (n=1,128)	77·6	44·7**	4·27 (3·18–5·75)

*=$p<0·01$; **=$p<0·001$.
#Adjusted odds ratio for non-theists compared with theists using forced entry logistic regression (adjusted for age, sex, practice).

have done the same. Several 'theist' groups were less likely to think that AVE was sometimes right (Catholic, Anglican, other Protestant, other Christian, 'other [including Moslem]) compared to the agnostics/atheists (Jews were similar to agnostics/atheists across all three questions).

Those who thought AVE was sometimes right based that view on secular ethical principles in 73·5 per cent of cases compared with those who thought that AVE was never right who based their views in 81·2% of cases on religious principles. This was a highly significant ($p<0·001$) difference.

One question asked where practitioners would turn for advice if faced with a request from a patient to hasten his or her death. While most doctors would seek advice from more than one place (74 per cent of doctors would seek advice from a colleague, 77 per cent from a relative or close friend of the patient, 62 per cent from nursing staff) only 33 per cent would turn to a religious adviser or counsellor for advice. Another question sought information on the values that would go into a decision about euthanasia to which only 22 per cent identified their views as being based *primarily* on 'ethical principles derived from religious views'.

Discussion

Almost all this sample of New South Wales medical practitioners answered a question asking for their religious affiliation. Of those who answered, 70 per cent identified themselves with a religious faith and about 30 per cent identified themselves positively as having no such affiliation. That such a high proportion of practitioners were willing to identify their religious affiliation is an indication of the confidence they had in the confidentiality guarantees given with the survey.

As shown in Table 1 the medical practitioners surveyed differed substantially from the population of New South Wales as a whole as regards their religious affiliation, possibly reflecting the selective and socially non-representative nature of recruitment to Australian medical schools. Our survey revealed lower than expected percentages of medical practitioners claiming adherence to the major Christian religions or to Islam, more Jews, Hindus and more agnostic/atheists than expected, and about the expected numbers of Buddhists and Moslems.

A noteworthy difference was the large percentage of doctors on the medical register of New South Wales who were willing to identify themselves as agnostic or atheist. If, as we believe, most medical practitioners grew up in homes which acknowledged some allegiance to a religion, the change in self-perception is likely to have been substantial. Additionally, 2·3 per cent of those who had been born into households in which they received religious training described themselves in the survey as 'lapsed', without choosing to identify themselves as either agnostic or atheist. They did this without there being a specific question on this matter and it is likely that the figure of 'lapsed' doctors obtained by us is an underestimate. The percentage identifying themselves as 'lapsed' is small but would be

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Table 3

Results according to religious affiliation

Question	% answering yes					chi square	p value
	Agnostic	Catholic	Anglican	Other Prot	Jewish		
Have ever been asked to hasten death	54	45	46	43	46	7·98	0·09
Have practised AVE if asked	35	18	28	25	35	10·2	0·04
Know other physicians who practise AVE	68	48	55	49	60	29	<0·001
Believe AVE is sometimes right	78	43	58	48	79	97	<0·001
Base this opinion on secular principles	80	47	59	46	74	98·9	<0·001
Believe AVE can be right AND							
– base view on secular principles	85	73	78	69	81	28	<0·001
– base view on religious principles	2	15	8	9	5	28	<0·001
(number believing AVE can be right)	265	100	125	86	44		
Believe AVE is not right AND							
– base view on secular principles	81	33	42	32	58	87	<0·001
– base view on religious principles	1	62	51	64	42	87	<0·001
(number believing AVE never right)	74	117	90	95	12		
Believe PAS is sometimes right	77	45	48	47	70	96	<0·001
Think Dutch situation good for Australia	79	43	57	47	72	96	<0·001
Think professional organisations should adopt a position on euthanasia	71	38	49	39	68	87	<0·001
Think law should be changed to allow AVE	77	42	55	44	77	104	<0·001
Think law should be changed to allow PAS	63	35	40	32	55	72	<0·001
Would practise AVE if it were legal	78	33	50	54	71	125	<0·001

greater than this figure were one to add numbers of those now identifying as atheist or agnostic who were raised initially in a religious home. The numbers of practitioners without religious affiliation may be one result of the critical questioning of authority and belief which is part of the intellectual tradition of tertiary study in Australia. Exclusion or inclusion of those who claimed to be 'lapsed' did not affect the outcomes of analyses.

Of all medical practitioners who had been asked to do so, more than one quarter acknowledged that they had taken steps to hasten death. The prelude to the particular question stated: 'In the following, we wish to focus on the use of active steps to bring about death, as distinct from the withdrawal of life-sustaining treatment'. The actual question asked was: 'Have you ever taken active steps to bring about the death of a patient who asked you to do so?'. So the affirmative responses were from those who were willing to acknowledge that they had done more than cease or withhold potentially curative or life-sustaining treatment. Because of the specific nature of the question it is likely that the figures indicate the minimum percentages of doctors in New South Wales acknowledging that they practise active euthanasia.

The percentages varied significantly with religious affiliation, which appears to be a significant determinant of the practices and of the attitudes of New South Wales medical practitioners to active euthanasia in 1993. Specifically, those doctors claiming to be agnostic or atheist were more likely to favour and to practise euthanasia and those who identified with any religion were more likely to be opposed, those most in favour being most likely to have taken steps to hasten death and those most opposed being most likely not to have taken such steps. Of those who did identify with a religion, Catholics were significantly different from other doctors in the strength and extent of their opposition to AVE. Investigators in the United States have noted similar findings (12), namely that there is an inverse relationship between affiliation with Catholicism by doctors and support for AVE. This finding is similar to that of Kuhse and Singer in 1988. Like them we did notice, however, that a small minority of Catholic doctors was willing to record that it had assisted patients to hasten death, in spite of quite explicit teachings of the Church to the contrary. That even 18 per cent of Catholics who had been asked to hasten death acknowledged that they had practised AVE was itself noteworthy and raises questions of how these Catholic practitioners reconciled their religious teaching with their responses to the needs of their patients. The results showed further the trend of opposition to AVE by all groups with a self-defined religious affiliation.

Morgan Gallup polls of the Australian community taken sequentially in Australia have shown that majorities of people surveyed are in favour of AVE, that majority support has persisted over many years of testing, that the percentages in favour are highest (83 per cent) in those with no religious affiliation and

Table 4

Relationship between responses to three questions and religious affiliation (analysis compares the likelihood of a positive response compared to the reference group of agnostics/atheists)

Religious group	Have been asked to hasten death		Have taken active steps to hasten death		Is AVE sometimes right?	
	Corrected # odds ratio	95% confidence interval	Corrected # odds ratio	95% confidence interval	Corrected # odds ratio	95% confidence interval
Agnostics/atheists (reference group)	1·00		1·00		1·00	
Measurement of the likelihood of a positive answer from different religious groups						
Catholic	0·73	0·53–1·02	0·44*	0·24–0·79	0·21*	0·15–0·30
Anglican	0·79	0·56–1·14	0·75	0·43–1·30	0·40*	0·27–0·58
Other Protestant	0·66*	0·46–0·96	0·63	0·35–1·12	0·26*	0·18–0·38
'Christian'	0·44	0·17–1·15	0·49	0·10–2·50	0·16*	0·06–0·40
Jewish	0·79	0·44–1·41	0·93	0·40–2·22	1·25	0·62–2·56
Other (incl Moslem)	0·50*	0·28–0·88	1·06	0·42–2·70	0·28*	0·16–0·48
Hindu	0·68	0·26–1·30	0·51	0·16–1·64	0·6	0·31–1·16
Buddhist	0·65	0·22–1·96	0·4	0·05–3·37	1·92	0·42–8·33

*=significantly different from reference group (agnostics/atheists). #adjusted for age, sex, and type of practitioner using forced entry logistic regression models (SPSS v5.0).

lowest (67 per cent) in Catholics (13). There was a high (two-thirds) level of support for euthanasia from even the least enthusiastic groups within the community in spite of the opposition of official Church teaching to such activity. That 67 per cent of professing Catholics answered yes to the Gallup poll question indicates a disjunction between community attitude and Church teaching on this matter, just as it shows a disjunction between the views of other religions and of those who answered the Gallup poll question.

We have remarked elsewhere that some of the demand for euthanasia may have its origin in the non-availability to some people of highest quality palliative and terminal care. Since such care could be provided if we allocated the service sufficient priority, training and resource, it is reasonable to encourage doctors to address deficiencies in skills and services directed to provision of highest quality palliative and terminal care. Our patients deserve no less and it seems from results we have obtained in this survey that many patients fear what lies ahead of them at the end of life. For those whose religious teachings are opposed, still to endorse and to acknowledge that they practise euthanasia, is one measure of how far our current services and arrangements fall short of what is possible or of what is needed.

Acknowledgements

The authors acknowledge gratefully the support of the Medical Board of New South Wales, for this study and financial support from the Voluntary Euthanasia Society of New South Wales, of which one of us (PB) is Patron.

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News and notes

Student paper competition: call for papers

The Student Interest Group of the Society for Health and Human Values is sponsoring a call for student-written papers in bioethics on the broad subject: *Values and Health Care: Diverse Perspectives.* The winner will receive a $1,000 award, plus up to $150 for expenses incident to presenting the paper at the SHHV annual meeting in San Diego, California, October 12–15 1995.

The topic could be addressed from the perspectives of such disciplines as philosophy, sociology, economics, law, journalism, anthropology, political science, theology, religious studies, literature, visual arts, nursing, or feminist or women's studies.

The following sample questions are offered to illustrate a few ways in which the topic might be approached:

What impact should bioethics have on public policy?

How does the fact-value distinction affect medical practice or bioethics?

How can we include diversity in moral and/or medical education in a meaningful way, without merely falling victim to the buzzword syndrome of the 1990s?

What should the relationship be between feminist analysis in bioethics and the ethic of care?

How can a deeper understanding of environment ethics inform the broader bioethics debate?

Papers must be documented, original, scholarly work of a single author, and must not already have been published or accepted for publication; submissions must not exceed 15 typed, double-space pages and **must be postmarked no later than April 15, 1995.** For eligibility and submission requirements, please contact; Merrill Watson, Student Interest Group Program Chair, SHHV PO Box 488, Haslett, MI 48840–0488: 517–339–1077 E-mail: ae 763@detroit.freenet.org.

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