

## SPECIAL ARTICLES

## ATTITUDES OF MICHIGAN PHYSICIANS AND THE PUBLIC TOWARD LEGALIZING PHYSICIAN-ASSISTED SUICIDE AND VOLUNTARY EUTHANASIA

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**Abstract Background.** There has been a continuing public debate about assisted suicide and the proper role, if any, of physicians in this practice. Legislative bans and various forms of legalization have been proposed.

**Methods.** We mailed questionnaires to three stratified random samples of Michigan physicians in specialties likely to involve the care of terminally ill patients: 500 in the spring of 1994, 500 in the summer of 1994, and 600 in the spring of 1995. Similar questionnaires were mailed to stratified random samples of Michigan adults: 449 in the spring of 1994 and 899 in the summer of 1994. Several different questionnaire forms were used, all of which included questions about whether physician-assisted suicide should be banned in Michigan or legalized under certain conditions.

**Results.** Usable questionnaires were returned by 1119 of 1518 physicians eligible for the study (74 percent), and 998 of 1307 eligible adults in the sample of the general public (76 percent). Asked to choose between legalization of physician-assisted suicide and an explicit ban, 56 percent of physicians and 66 percent of the public sup-

ported legalization, 37 percent of physicians and 26 percent of the public preferred a ban, and 8 percent of each group were uncertain. When the physicians were given a wider range of choices, 40 percent preferred legalization, 37 percent preferred "no law" (i.e., no government regulation), 17 percent favored prohibition, and 5 percent were uncertain. If physician-assisted suicide were legal, 35 percent of physicians said they might participate if requested — 22 percent would participate in either assisted suicide or voluntary euthanasia, and 13 percent would participate only in assisted suicide. Support for physician-assisted suicide was lowest among the strongly religious.

**Conclusions.** Most Michigan physicians prefer either the legalization of physician-assisted suicide or no law at all; fewer than one fifth prefer a complete ban on the practice. Given a choice between legalization and a ban, two thirds of the Michigan public prefer legalization and one quarter prefer a ban. (N Engl J Med 1996;334:303-9.)

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THE legalization, in some form, of physician-assisted suicide has been the goal of referendums introduced in the states of Washington (defeated in 1991), California (defeated in 1992), and Oregon (passed in 1994, but not yet implemented because of court challenges). Assisted suicide has also been the focus of legislative and judicial action in Michigan during the past several years, prompted by the actions of Dr. Jack Kevorkian. Moreover, assisted suicide and voluntary euthanasia (i.e., euthanasia requested by the patient) continue to be widely discussed in the medical and bioethics literature.<sup>1-10</sup>

A fundamental issue is whether society should ever permit any form of assisted suicide. There are well-developed arguments on both sides.<sup>6</sup> Supporters of the practice emphasize the relief of suffering, individual autonomy, and the patient's right to be free from paternalistic state intrusion.<sup>11-14</sup> Advocates also contend that allowing a small number of assisted suicides under carefully controlled and narrowly restricted conditions is better

than acceding to secret and unregulated activity. Opponents stress that legalizing assisted suicide would represent a profound change in social values, that it would have serious unintended consequences, and that any gains from accepting the practice are not worth the risks.<sup>7,15-18</sup>

Even if assisted suicide were to be permitted under some conditions, a second issue is whether physicians should ever participate in it. Some believe that participation would run counter to the physician's role as a healer and compromise the trust patients place in their physicians,<sup>7</sup> but others argue that it would not necessarily violate professional integrity.<sup>4</sup> In any event, physicians are logical candidates for participation; they can assess a patient's medical and emotional status, and they know what pharmacologic agents and modes of administration would meet the needs of particular patients. More important, physicians are becoming better trained to provide palliative care, so they are ideally suited to demonstrate to patients that acceptable alternatives to assisted suicide may exist.<sup>5,6,8,9</sup> It thus seems likely that if any form of assisted suicide is legalized, legislators will want to entrust the responsibility of assistance to physicians.

Prompted by the debate over physician-assisted suicide in Michigan, and in the hope of providing useful information to the Michigan legislature, we undertook a series of surveys of Michigan physicians and the state's general public, beginning in the spring of 1994.

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Table 1. Plans A and B for the Legalization of Physician-Assisted Suicide.

FEATURES COMMON TO BOTH PLANS		
<b>Purposes</b>		
To permit terminally ill patients to request and receive a physician's assistance in hastening death.		
To provide safeguards against abuse.		
<b>Legal safeguards</b>		
No physician or health care provider shall be required to have any involvement with physician-assisted suicide if he or she is opposed to it.		
Physicians who voluntarily agree to assist in suicide will be protected from prosecution.		
There will be criminal liability for assisting in a suicide without following the provisions of the law regulating physician-assisted suicide.		
A confidential record-keeping system will require physicians who participate in physician-assisted suicide to report all such cases.		
<b>Eligibility requirements</b>		
The patient must be an adult.		
The patient must be mentally competent and not suffering from clinical depression.		
The patient must be terminally ill, with death expected to occur within six months, and must be suffering unrelenting pain that he or she finds unacceptable.		
<b>Requests for physician-assisted suicide</b>		
Only the patient can request physician-assisted suicide.		
The request for physician-assisted suicide must be made by the patient in writing (or in some other form, such as videotape, if the patient is unable to write).		
A second request must be made after a waiting period of at least seven days.		
<b>Procedural safeguards</b>		
A second physician must examine the patient and agree with the diagnosis and prognosis.		
A physician must certify that the patient is mentally competent and not suffering from clinical depression.		
All reasonable palliative-care alternatives must be explained and offered to the patient.		
DIFFERENCES BETWEEN THE PLANS		
TASK	PERSON WITH PRIMARY RESPONSIBILITY	
	Plan A	Plan B
Ensuring that procedural safeguards are followed	The patient's physician, in cooperation with other specialists	The palliative-care consultant, with the assistance of other specialists as necessary
Deciding whether the patient's request can be honored	The patient's physician	The palliative-care consultant (or palliative-care committee, in some cases)
Assisting in the suicide	Ordinarily, the patient's physician	Ordinarily, the patient's physician
Filing a report	The patient's physician	The palliative-care consultant
Conducting retrospective professional review	No specific provisions for review	The palliative-care committee

Preliminary results of the initial survey were reported in the *Journal*.<sup>9</sup> We conducted a second survey of physicians and the public in the summer of 1994 and a third survey, of physicians alone, in the spring of 1995. This article reports the major findings from all three surveys.

## METHODS

### Respondents

We selected our target sample of Michigan physicians from the American Medical Association master list, which contains both members and nonmembers of that group. After excluding physicians in residency training and in fellowships, we further narrowed the sample to include only physicians who were not federal employees, were currently practicing in Michigan, were either full-time hospital staff members or in office-based practice, directly cared for patients, and practiced specialties that involve the care of patients with terminal or chronic illness. More than half the doctors who met the first four cri-

Table 2. Attitudes of Physicians and the Public toward Physician-Assisted Suicide and Voluntary Euthanasia.

QUESTIONNAIRE ITEM	RESPONSE CHOSEN*	
	PHYSICIANS	PUBLIC
	<i>percent</i>	
<b>Preferences for legalization or a ban</b>		
"Suppose that the Michigan legislature were deciding between just two choices: (1) enacting a law banning all physician-assisted suicide, or (2) enacting Plan A [or B†] for physician-assisted suicide. Which do you think would be the better choice for the legislature?"		
It should definitely ban all physician-assisted suicide.	29	22
It should probably ban all physician-assisted suicide.	8	4
Uncertain, can't say.	8	8
It should probably enact Plan A [B].	31	28
It should definitely enact Plan A [B].	25	38
<b>Attitudes toward voluntary euthanasia</b>		
"Which of the following best describes your views about whether a physician should ever be allowed to take the final action in response to a patient's request for assisted death?"		
I oppose any form of physician-assisted death or suicide.	35	25
I support some forms of physician-assisted suicide, but only if the patient takes the final action.	15	16
I support the physician taking the final action, but only when it is impossible for the patient to do so.	27	29
I support either the patient or physician taking the final action.	17	24
Uncertain [or other].	5	6
<b>Attitude toward participation in physician-assisted suicide</b>		
"Suppose physician-assisted suicide became legal according to Plan A [B], and suppose it were expanded to permit physicians to administer the substance to patients unable to do so themselves. Would you be likely to participate if requested by a patient, assuming all the criteria and safeguards outlined for Plan A [B] were in place?"		
I would not participate in any form of physician-assisted death or suicide.	52	—
I might be willing to participate in some forms of physician-assisted suicide, but only if the patient takes the final action.	13	—
I might be willing to participate with either the patient or physician taking the final action.	22	—
Uncertain.	10	—
I prefer not to answer.	2	—
<b>Likelihood of requesting physician-assisted suicide</b>		
"Please try to imagine that doctors discovered that you have a terminal illness that is certain to involve a great deal of pain and suffering. If physician-assisted suicide were legally available, do you think you might request it for yourself?"		
Yes, definitely.	—	24
Probably.	—	24
Uncertain, can't say.	—	22
Probably not.	—	9
Definitely not.	—	21

\*For all percentages, the 95 percent confidence intervals were less than or equal to  $\pm 3$  percentage points. Because of rounding, not all percentages total 100.

†Plan B was in the 1995 survey (physicians only); Plan A was in all others.

teria also met the fifth. From the approximately 8000 physicians in the state who qualified, geographically stratified random subgroups were selected to constitute the subsamples for the three separate surveys: 500 physicians for the spring of 1994, 500 for the summer of 1994, and 600 for the spring of 1995.

The target sample of Michigan adults was selected from a commercially maintained sample frame (Survey Samplings, Fairfield, Conn.) derived from national telephone-directory listings and information from administrative records (such as those for driver's licenses). Geographically stratified, random subgroups were selected to

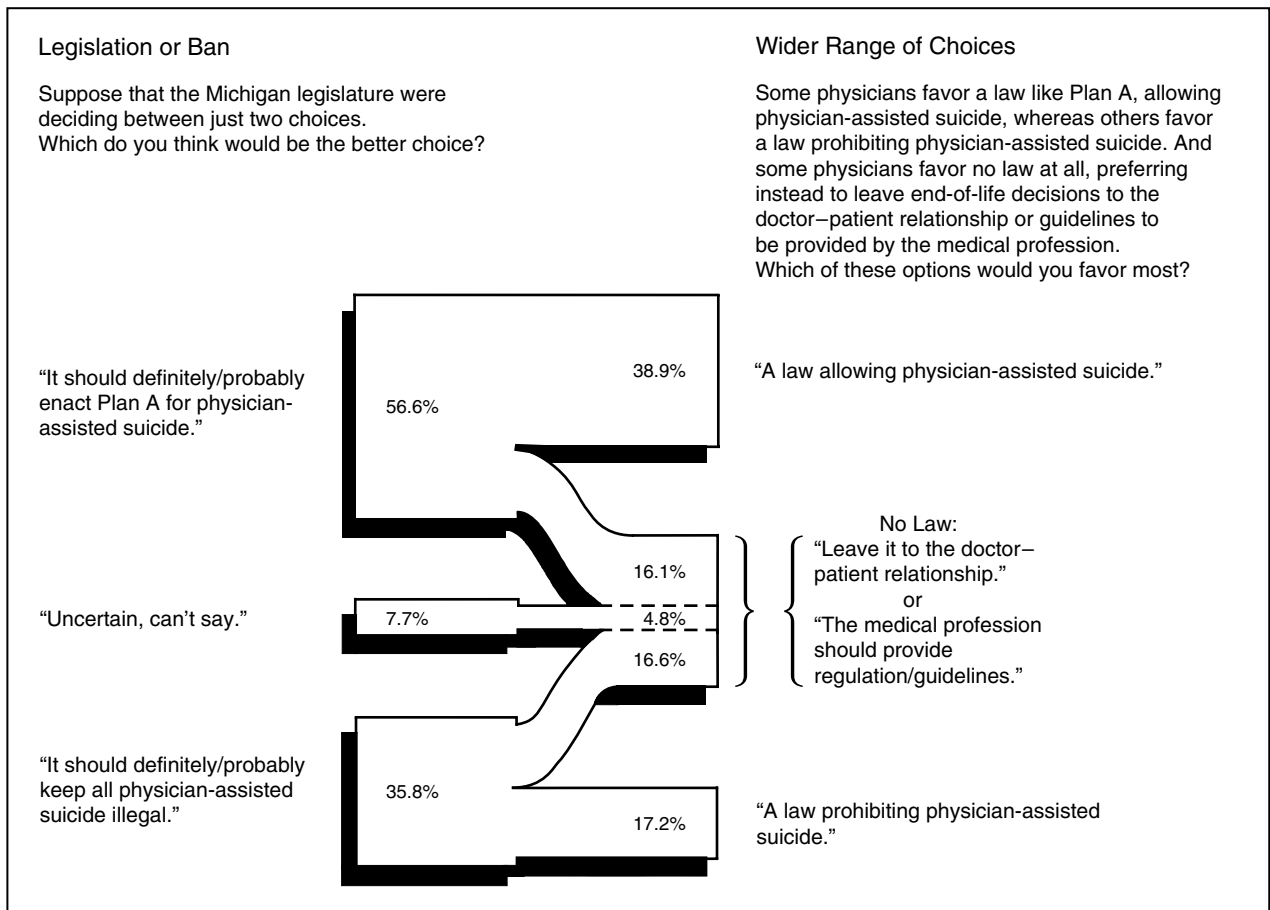


Figure 1. How Physicians Modified Their Choices between Legalizing and Banning Assisted Suicide When "No Law" Options Were Included.

The figure is based on the responses of the 1071 physicians who answered both questions. The right-hand side of the figure shows the percentages of physicians who gave the responses shown, but it omits the 4.7 percent who responded "Don't know/not sure" to the second version and the 1.8 percent who gave answers other than those shown. The percentages thus differ slightly from those cited in the text. The questions shown refer to Plan A. Some questionnaires referred to "Plan A or B."

constitute subsamples: 449 adults for the spring of 1994, and 899 for the summer of 1994.

**Questionnaires**

We used a variety of questionnaires to explore different questions and wordings, and to assess whether the responses to certain core questions (common to all the forms) were influenced by the order of the questions, the other questions asked, or information given on the questionnaire.<sup>20,21</sup> Each form of the questionnaire provided background information on arguments raised in the debate about physician-assisted suicide. To guard against bias, the questionnaires were developed in consultation with medical and legal experts and with spokespersons on both sides of the assisted-suicide debate in Michigan.

All questionnaires described a plan that would legalize physician-assisted suicide for terminally ill adult patients suffering unacceptable pain. Extensive safeguards were included (Table 1).

All 1994 surveys presented what we called Plan A for physician-assisted suicide, adapted from work by a subcommittee of the Michigan Commission on Death and Dying and similar to the Washington and California state referendums. The 1995 survey of physicians involved three different forms. One form presented what we called Plan B, which was designed to reflect some, but not all, of the features of a proposal by Miller et al.<sup>3</sup> that called for a system of specially certified "palliative-care consultants" monitored by "palliative-care com-

mittees." Two other forms presented both Plan A and Plan B. For comparability, Plan B was kept consistent with Plan A in overall purpose, eligibility requirements, and legal safeguards. The plans differed in the implementation of procedural safeguards (Table 1).

All respondents, both physicians and the general public, were asked whether the Michigan legislature should ban physician-assisted suicide or enact Plan A (or Plan B, for some physicians), and whether the plan should include voluntary euthanasia (defined as allowing a physician to "take the final action" that brings on a patient's death). Physicians also were asked about their personal willingness to participate in physician-assisted suicide and voluntary euthanasia, their experience with terminally ill patients, and whether having "no law" (i.e., leaving the issue up to "the doctor-patient relationship" or "the medical profession") would be a better choice for Michigan than either legalization or prohibition.

Questionnaires were mailed according to an established survey-mailing protocol to increase respondents' cooperation.<sup>22</sup>

**RESULTS**

Among the 1600 Michigan physicians in the target sample, 82 were found to be ineligible because they were either no longer practicing in Michigan (62 potential respondents) or deceased (5), or because the mailed ques-

Table 3. Attitudes toward Physician-Assisted Suicide and Voluntary Euthanasia According to Selected Characteristics of Respondents.\*

GROUP AND CHARACTERISTIC	No. (%)†	WOULD LEGALIZE	WOULD LEGALIZE	WOULD PARTICIPATE IN
		PHYSICIAN-ASSISTED SUICIDE	VOLUNTARY EUTHANASIA	PHYSICIAN-ASSISTED SUICIDE‡
		<i>percent</i>		
<b>Physicians</b>				
<b>Sex</b>				
Male	954 (86)	56	45	35
Female	159 (14)	54	41	41
Missing data	6			
Eta		0.007	0.025	0.024
<b>Age (yr)</b>				
30–39	291 (26)	58	48	39
40–49	348 (31)	54	45	37
50–59	261 (23)	59	44	32
≥60	218 (19)	50	40	33
Missing data	1			
Eta		0.070	0.057	0.062
r		–0.037	–0.045	–0.056
<b>Importance of religion§</b>				
Not important	62 (17)	68	60	56
A little important	85 (23)	77	63	57
Pretty important	99 (27)	62	42	35
Very important	127 (34)	34	24	16
Missing data	19			
Eta		0.409¶	0.393¶	0.376¶
r		–0.376¶	–0.378¶	–0.363¶
<b>Medical specialty</b>				
Family practice, general practice, and general internal medicine	632 (57)	54	44	39
Internal-medicine specialties	97 (9)	53	40	39
Surgery	203 (18)	56	40	29
Anesthesiology	107 (10)	63	56	37
Other	79 (7)	62	49	26
Missing data	1			
Eta		0.060	0.079	0.095
<b>Frequency of experience treating terminally ill patients</b>				
Never	45 (4)	73	69	38
Seldom	180 (17)	68	49	30
Sometimes	424 (41)	55	46	39
Often	279 (27)	51	42	33
Very often	110 (11)	44	34	38
Missing data	81			
Eta		0.172¶	0.144¶	0.089
r		–0.171¶	–0.138¶	0.013

tionnaires had been returned to the sender at least twice (15). Of the remaining 1518 eligible physicians, 1119 (74 percent) returned usable questionnaires. Among the 1348 Michigan adults in the target sample, 41 were found to be ineligible because they had died or moved out of the state. Of the remaining 1307 eligible respondents, 998 (76 percent) returned usable questionnaires.

The three survey periods and multiple questionnaire formats were not associated with any statistically significant differences in our results. Accordingly, the findings from the subsamples were combined and data are reported only for the total samples.

#### Attitudes toward Legalization

Respondents were asked whether the Michigan legislature should ban all physician-assisted suicide or legalize it by enacting Plan A (in the 1994 surveys) or Plan B (in the 1995 survey). Table 2 shows that 56 percent of physicians and 66 percent of the public thought the legislature should probably or definitely enact the plan

and that 37 percent of physicians and 26 percent of the public thought the legislature should probably or definitely ban all physician-assisted suicide; 8 percent in each group were uncertain.

Respondents then were asked whether voluntary euthanasia should be legally available in specified situations. Table 2 shows that many supported the physician's taking the final action to cause death, at least under some circumstances (44 percent of physicians and 53 percent of the public); a smaller group supported assisted suicide but rejected voluntary euthanasia (15 percent of physicians and 16 percent of the public).

#### Participation by Physicians

Physicians were asked whether they themselves might be willing to participate in physician-assisted suicide or voluntary euthanasia if the practices were legalized. Fifty-two percent said they would not; 13 percent said they might participate only in assisted suicide; 22 percent said they might participate in both practices;

Table 3. Continued.

GROUP AND CHARACTERISTIC	No. (%) <sup>†</sup>	WOULD LEGALIZE	WOULD LEGALIZE	WOULD PARTICIPATE IN
		PHYSICIAN-ASSISTED SUICIDE	VOLUNTARY EUTHANASIA	PHYSICIAN-ASSISTED SUICIDE <sup>‡</sup>
		<i>percent</i>		
<b>Public</b>				
<b>Sex</b>				
Male	430 (43)	67	62	55
Female	568 (57)	65	53	43
Missing data	0			
Eta		0.061	0.119¶	0.121¶
<b>Age (yr)</b>				
<30	130 (13)	64	54	36
30–39	210 (21)	73	69	51
40–49	203 (20)	66	60	48
50–59	140 (14)	66	56	52
60–69	153 (15)	64	51	51
≥70	162 (16)	58	45	50
Missing data	0			
Eta		0.083	0.138¶	0.070
r		–0.060	–0.090¶	–0.045
<b>Importance of religion</b>				
Not important	80 (8)	89	88	75
A little important	205 (22)	85	76	67
Pretty important	277 (29)	78	64	56
Very important	386 (41)	42	35	27
Missing data	50			
Eta		0.459¶	0.462¶	0.460¶
r		–0.421¶	–0.440¶	–0.429¶
<b>Experience with terminal illness</b>				
No	253 (34)	67	54	49
Yes	495 (66)	65	58	49
Missing data	250			
Eta		0.039	0.003	0.031

\*Relations are measured by two correlation coefficients, when appropriate, with dependent variables (views about physician-assisted suicide and voluntary euthanasia) treated as interval scales. Eta is a “universal” measure of relation because it captures curvilinear as well as linear relations.<sup>23,24</sup> Possible values for eta range from 0.0 (no correlation) to 1.0 (perfect correlation). Pearson’s product-moment correlation, r, can be thought of as a special case of eta, because it reflects only linear relations<sup>25</sup>; it is shown only for interval-scaled independent variables. Possible values for r range from –1.0 (perfect negative correlation) through 0.0 (no correlation) to 1.0 (perfect positive correlation). When eta is larger than r, it indicates that some portion of the relation is nonlinear.

<sup>†</sup>Percentages are calculated with the number of respondents who answered a particular question as the denominator. Because of rounding, percentages may not total 100.

<sup>‡</sup>Refers to the likelihood of participating in physician-assisted suicide (physicians) or requesting physician-assisted suicide (public).

<sup>§</sup>This item appeared only in the 1995 questionnaire. Data are therefore shown for only 392 physicians. Religious affiliation (Catholic, Baptist, Methodist, and so forth) was also included, but it had a much weaker relation to attitudes toward physician-assisted suicide and voluntary euthanasia.

¶F-ratio significantly different from zero; two-tailed P<0.01.

||Includes emergency medicine, obstetrics and gynecology, occupational medicine, physical medicine and rehabilitation, radiation oncology, and radiology.

10 percent were uncertain; and 2 percent preferred not to answer (Table 2). In the 1995 survey, physicians who said they would not participate were asked, “Even though you would not participate, would you be willing to refer the patient to such services?” Of the 186 physicians who would not participate in either practice, 43 percent said they would refer patients; 38 percent said they would not; and 19 percent were uncertain.

Respondents from the general public were asked whether they might request physician-assisted suicide for themselves, if it were legalized and they were facing a terminal illness with much pain and suffering. Forty-eight percent said they probably or definitely would request it; 30 percent said they probably or definitely would not; and 22 percent were uncertain (Table 2).

**A Wider Range of Choices**

An item included only in the physicians’ questionnaires broadened the range of choices to include “no law” options (as detailed in Fig. 1). Asked which option they “would favor most,” 40 percent of physicians fa-

vored a law permitting physician-assisted suicide; 17 percent favored a law prohibiting it; 37 percent favored having “no law” — leaving the issue to be decided either by “the doctor–patient relationship” (22 percent) or on the basis of “guidelines or regulations” from “the medical profession” (15 percent); and 5 percent were uncertain.

Figure 1 compares the physicians’ responses to the initial two-option choice (legalization or a ban) with their responses to the later question that also included the “no law” options. Nearly half the physicians who initially chose a ban over legalization in fact preferred one of the “no law” options. Far fewer — just over one quarter — of those who initially chose legalization preferred “no law” when given the option.

**Plan A or Plan B**

The 1995 survey of physicians included three separate forms, one presenting only Plan B, one presenting Plan A first and then Plan B, and one reversing that order. The latter two forms included the question: “As-

suming physician-assisted suicide were to be legalized, which do you think would be the better plan for doing so, Plan A or Plan B?" If we combine the results for those two forms to balance any order effects, then 42 percent of the physicians preferred Plan B, 27 percent preferred Plan A, 26 percent selected the response "I am unwilling or unable to state a preference because I think all physician-assisted suicide should be banned," and 4 percent were uncertain (264 physicians responded; 95 percent confidence intervals,  $\pm 6$  percent or less).

For the questionnaires that presented both legalization plans, we tabulated the respondents' preferences for Plan A or a ban and Plan B or a ban. Among those who preferred Plan A to prohibition, 93 percent also preferred Plan B to a ban (95 percent confidence interval, 88 to 96 percent). However, among those who preferred Plan B to prohibition, only 79 percent also preferred Plan A to a ban (95 percent confidence interval, 71 to 85 percent).

#### **Personal Characteristics Correlated with Views on Assisted Suicide**

Table 3 presents personal characteristics of Michigan physicians in relation to their views on physician-assisted suicide and voluntary euthanasia, as well as similar data for the Michigan public. There were no clear differences among physicians according to sex, but in the general public men were slightly more likely than women to support legalization and to consider assisted suicide for themselves. There was a slight tendency, among both physicians and the public, for older respondents to be less likely to support legalization. The most important personal characteristic was religion — those who considered religion very important in their lives were much less likely both to support legalization and to consider personal involvement in assisted suicide, either as providers (physicians) or requesters (the public), than were people for whom religion was less important (Table 3).

Table 3 also compares the attitudes toward legalization and participation among physicians in different specialties. We did not observe any strong or consistent differences according to specialty. Among the physicians as a group, doctors who frequently treated terminally ill patients were less likely to support legalization of the practices in question, but not less likely to be willing to participate in the practices if they became legal (Table 3).

Two thirds of Michigan adults reported that they or their close friends or family members had been faced with a terminal illness, although having had such an experience was not linked to any overall differences in support for legalization or in the likelihood of requesting physician-assisted suicide (Table 3).

#### **DISCUSSION**

Public support in the United States for legalizing physician-assisted suicide, voluntary euthanasia, or both, seems to be increasing<sup>25,26</sup>; our findings with respect to

Michigan are consistent with that trend. When asked to choose between two courses of legislative action, about two thirds of Michigan adults favored the legalization of physician-assisted suicide, and about one quarter preferred a ban on the practice. A majority of Michigan physicians also favored legalization rather than a ban, if given only those two choices. But what many Michigan physicians most preferred is that the legal system stay out of this area — a position consistent with that of the Michigan State Medical Society, which opposes any legislation regarding physician-assisted suicide, one way or the other. Attractive as the "no law" option may be to some physicians, policy analyses suggest that it would be unrealistic and unworkable in any form.<sup>6,27</sup>

Most of the Michigan physicians surveyed in 1995 were willing to choose between two plans for legalization. The more frequently chosen option was Plan B, which assigned many responsibilities to palliative-care consultants and committees instead of burdening the physician, as was done in Plan A. It is worth noting that very few physicians who preferred Plan A ruled out Plan B (that is, preferred an outright ban to Plan B), whereas the reverse was not true.

The willingness of physicians to trade some degree of independence in patient care for the assistance of palliative-care consultants may reflect several considerations: physicians' concern about limitations in their own palliative-care skills; the moral, ethical, and legal liabilities associated with participating in physician-assisted suicide; and a preference for consultation among peers, which may be more familiar and comfortable to physicians than a legally prescribed protocol.

About one third (35 percent) of physicians thought they might participate in assisted suicide if the practice were legalized; some others were uncertain. Among the 52 percent who would not participate themselves, many indicated that they would be willing to refer patients to practitioners who would. This parallels attitudes toward abortion in some respects; many physicians who oppose a medical action on moral grounds are nevertheless willing to make referrals out of respect for a patient's autonomy.

Physicians' personal experiences and values influence their positions on these issues. For example, the doctors who had the least contact with terminally ill patients were the most likely to support the legalization of assisted suicide, a finding consistent with the attitude of physicians in the state of Washington.<sup>2</sup> The widely replicated finding that strongly religious people are the most likely group to oppose such legalization<sup>28</sup> was as evident in our study among physicians as among all adults in Michigan. Of the doctors who were asked about the importance of religion in their lives, those who said it was "very important" were the least likely to support legalization. Nevertheless, half of them were still willing to choose between the two legalization plans, and they favored Plan B by a three-to-one margin. This suggests that among those with the greatest reservations about le-

galization, the additional safeguards in Plan B — palliative-care consultants and committees — made that plan more acceptable than Plan A.

Our study differs from most earlier studies in that we surveyed both physicians and the general public using very similar questions, in order to make meaningful comparisons. Also, we asked respondents to consider specifically what the state legislature should do if the only choices were legalizing physician-assisted suicide with substantial restrictions or banning it entirely. We surveyed these groups at three different times and varied the wording and format of our questionnaires substantially, yet our surveys had highly similar results. This high degree of replication<sup>29</sup> leaves us confident that the findings reported here are robust.

Our results may have several policy implications. On the one hand, given the overall stability of our findings at a time when assisted suicide was widely debated in Michigan, it appears unlikely that any new plan for legalization could win over large numbers of heretofore reluctant physicians, voters, or legislators. On the other hand, it is already the case, among both Michigan physicians and the state's adult population in general, that those who support the carefully defined legalization of physician-assisted suicide clearly outnumber those who support a total ban. Moreover, many in the state would also support voluntary euthanasia, especially for patients unable to act for themselves. These complex issues should not be decided by opinion polls, of course, but neither should medical ethicists or political decision makers ignore the strongly held views of those who will be most affected by legislative decisions on the question — physicians and their potential patients.

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#### REFERENCES

- Annas GJ. Death by prescription: the Oregon initiative. *N Engl J Med* 1994; 331:1240-3.
- Cohen J, Fihn S, Boyko E, Jonsen A, Wood R. Attitudes toward assisted suicide and euthanasia among physicians in Washington State. *N Engl J Med* 1994;331:89-94.
- McCarrick PM. Active euthanasia and assisted suicide. *Kennedy Inst Ethics J* 1992;2:79-100.
- Miller FG, Brody H. Professional integrity and physician-assisted death. *Hastings Cent Rep* 1995;25(3):8-17.
- Miller FG, Quill TE, Brody H, Fletcher JC, Gostin LO, Meier DE. Regulating physician-assisted death. *N Engl J Med* 1994;331:119-23.
- The New York State Task Force on Life and the Law. When death is sought: assisted suicide and euthanasia in the medical context. Albany, N.Y.: Health Research, 1994.
- Pellegrino ED. Doctors must not kill. *J Clin Ethics* 1992;3:95-102.
- Quill TE. Death and dignity: making choices and taking charge. New York: W.W. Norton, 1993.
- Quill TE. Doctor, I want to die: will you help me? *JAMA* 1993;270:870-3.
- Physician-assisted suicide: toward a comprehensive understanding: report of the Task Force on Physician-assisted Suicide of the Society for Health and Human Values. *Acad Med* 1995;70:583-90.
- Brody H. Assisted death — a compassionate response to a medical failure. *N Engl J Med* 1992;327:1384-8.
- Quill TE, Cassel CK, Meier DE. Care of the hopelessly ill: proposed clinical criteria for physician-assisted suicide. *N Engl J Med* 1992;327:1380-4.
- Teno J, Lynn J. Voluntary active euthanasia: the individual case and public policy. *J Am Geriatr Soc* 1991;39:827-30.
- Weir RF. The morality of physician-assisted suicide. *Law Med Health Care* 1992;20:116-26.
- AGS Public Policy Committee. Voluntary active euthanasia. *J Am Geriatr Soc* 1991;39:826.
- Kamisar Y. Are laws against assisted suicide unconstitutional? *Hastings Cent Rep* 1993;23(3):32-41.
- Orentlicher D. Physician participation in assisted suicide. *JAMA* 1989;262:1844-5.
- Singer PA, Siegler M. Euthanasia — a critique. *N Engl J Med* 1990;322:1881-3.
- Bachman JG, Doukas DJ, Lichtenstein RL, Alcsér KH. Assisted suicide and euthanasia in Michigan. *N Engl J Med* 1994;331:812-3.
- Schuman H, Presser S. Questions and answers in attitude surveys: experiments on question form, wording, and context. New York: Academic Press, 1981.
- Schwarz N, Sudman S, eds. Context effects in social and psychological research. New York: Springer-Verlag, 1992.
- Dillman DA. Mail and telephone surveys: the total design method. New York: John Wiley, 1978.
- Nunnally JC. Psychometric theory. New York: McGraw-Hill, 1967.
- Vogt WP. Dictionary of statistics and methodology: a nontechnical guide for the social sciences. Newbury Park, Calif.: Sage, 1993.
- Blendon RJ, Szalay US, Knox RA. Should physicians aid their patients in dying? The public perspective. *JAMA* 1992;267:2658-62.
- Wood FW, ed. An American profile — opinions and behavior, 1972-1989: opinion results on 300 high-interest issues derived from the General Social Survey conducted by the National Opinion Research Center. Detroit: Gale Research, 1990.
- Final report of the Michigan Commission on Death and Dying. Legislative Service Bureau, State of Michigan. Lansing, Mich.: Michigan Commission on Death and Dying, 1994. (MCDD FOIA DOC. A-902.)
- Finlay B. Right to life versus the right to die: some correlates of euthanasia attitudes. *Sociol Soc Res* 1985;69:548-60.
- Campbell DT, Fiske DW. Convergent and discriminant validation by the multitrait-multimethod matrix. *Psychol Bull* 1959;56:81-105.

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