

Perception of physician-assisted suicide among Egyptian psychiatrists: cultural perspective

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Aims and method To explore the views of Egyptian psychiatrists on physician-assisted suicide, focusing on demographical, spiritual, legal and clinical domains. We surveyed the views of psychiatrists in four Egyptian counties using a structured questionnaire with a five-point Likert response scale.

Results A total of 160 psychiatrists completed the questionnaire (response rate 82%). Of these, 50% described the influence of their religious beliefs on their medical practice as very strong/strong and 12.5% as weak/nil. The majority (75%) said they would disagree or strongly disagree with supporting physician-assisted suicide for a terminally ill patient; a similar proportion (76%) were against passive euthanasia. The majority (77%) felt that physician-assisted suicide was against their religious beliefs; there was no significant difference between Muslims and Christians. The majority (82.4%) believed that physician-assisted suicide could/will be abused.

Clinical implications Careful consideration should be given to the safeguarding of psychiatric patients if physician-assisted suicide is legalised. Future studies on the views of clinicians should explore the influence of cultural differences rather than religious beliefs.

Declaration of interest None.

Physician-assisted suicide is a controversial subject that has captured the interests of the media, the public, politicians and the medical profession. Although active euthanasia and physician-assisted suicide are illegal in most parts of the world, with the exception of Switzerland and The Netherlands, there is pressure from some politicians and some patient support groups to legalise the practice in the UK and the rest of Europe, which could possibly affect many other parts of the world. As we live in multicultural and multireligious societies, it is essential to understand the effects of cultural and religious background on the decision-making process in the area of physician-assisted suicide.

The ethics of euthanasia have always attracted wide debate.¹ Euthanasia is the practice of ending life in a painless manner. The definition differs slightly between countries, but euthanasia is generally defined as ‘a deliberate intervention undertaken with the express intention of ending a life, to relieve intractable suffering’.² Euthanasia conducted with the patient’s consent is termed ‘voluntary euthanasia’. Euthanasia can also be classified as active or passive – passive euthanasia entails the withholding of common treatments whereas active euthanasia includes the administration of an active drug to precipitate death.³ Physician-assisted suicide is the practice of providing a competent patient with a prescription for medication for the patient to use with the primary intention

of ending his or her own life;⁴ the patient has to self-administer the medication, directly or through a machine. It is widely expected that psychiatrists will be asked to assess a patient’s mental state and mental capacity in the process of making the final decision about whether physician-assisted suicide can go ahead.

Social and cultural aspects

Social and technological forces have combined to give individuals an unprecedented sense of control over their physical life. It seems consistent with this extraordinary level of control that we would also exercise an urge for further control over the time and place of death, with the consequent movement to legalise assisted suicide.⁵ However, inadequate attention has been given to the cultural and socioeconomic backgrounds underlying the different views of assisted suicide. Available literature shows that cultural differences may account for some discrepancies related to assisted suicide.⁶ Accordingly, clinical decisions are necessarily influenced by the social structure and context in which they are made. Sociological influences on the clinical decision include the social characteristics of patients and physicians, the patterns of social interaction and authority in clinical settings, and the structure of healthcare organisations.⁶

It is important that doctors try to know their patients, not only in terms of abnormalities in the body system but also as people situated in broader social, economic, historical, religious and cultural contexts.⁷ In encounters with healthcare professionals, the patient's understanding of illness and how they communicate about their health problems is shaped by many factors.⁸ We also need to understand the characteristics of physicians, the dynamics of the relationships between professionals and patients, and the impact of societal structures and cultural and religious beliefs on those relationships. Only by understanding these matters can we identify and modify the structural inequities in medicine that compromise the interests of competent people when making end-of-life decisions.

An Australian study defined a terminal state as one leading to death in the 'normal course' of illness progression;⁹ the study also highlighted the difficulty in applying this definition to different clinical cases. An American study illustrated the difficult position psychiatrists could find themselves in if mental capacity issues become a prerequisite for assessment of patients requesting physician-assisted suicide: only 6% of the Oregon psychiatrists questioned were 'very confident' that in a single evaluation they could adequately assess whether a psychiatric disorder was impairing the judgement of a patient requesting assisted suicide.¹⁰

A survey conducted by the Association for Palliative Medicine of Great Britain and Northern Ireland supports the view that the majority of palliative medicine specialists oppose a change in the law on assisted dying. The Association argues that the opinions of those who work with people who are dying must be taken on board.¹¹ A study of the opinions of 3733 UK doctors on the legalisation of medically assisted dying (euthanasia and physician-assisted suicide), contrasting with the UK general public, found that the majority of doctors were opposed to its legalisation.¹² This study also found that a strong religious belief was independently associated with opposition to assisted dying. There is a strong stigma in Egyptian society towards suicide, hence the paucity of research in the field of suicide and physician-assisted suicide. This situation is no different from that in the rest of the Arabic-speaking countries in the Middle East.¹³

Psychiatric services in Egypt

Egypt is a middle-income country with a population of approximately 76 million and a growing life expectancy. The proportion of older people in Egypt is increasing at a faster rate than any other age group, which, as in the UK, is posing a real challenge to health providers.¹⁴ Egypt has 13 medical schools; each has a department of psychiatry and provides service to the local community. There are about 120 000 doctors in the country (1 doctor/650 citizens); 1000 psychiatrists, including those in training (1 psychiatrist/77 500 citizens); and about 9000 psychiatric beds (12 beds/100 000 population).¹⁵ The Department of Health is leading a policy to deinstitutionalise psychiatric care and provide community care, which may reduce the number of psychiatric beds. Psychiatric training is well regulated and there is a desire to develop old age psychiatry as a subspecialty, but so far the vast majority of psychiatrists

consider themselves as general psychiatrists and see patients of any age.

Aim of the study

Our aim was to survey the views of Egyptian psychiatrists on physician-assisted suicide, focusing on demographical, spiritual, legal and clinical domains. In our study we also looked into psychiatrists' opinions in relation to ageing and dementia. We questioned whether different religious beliefs would have an impact on psychiatrists' views on physician-assisted suicide.

Method

We surveyed the views of psychiatrists in four Egyptian counties (Cairo, Giza, Helwan, Alexandria). The population in the study area is around 24 million, 32% of the total Egyptian population. Our questionnaire was circulated to all psychiatrists working at the main psychiatric hospitals in the four counties. We used a fully anonymous, structured questionnaire with a five-point Likert response scale. The design of the questionnaire was based on the available literature.^{16–18} It consisted of three sections: Section I covered demographic data, Section II explored the psychiatrists' views on physician-assisted suicide, and Section III investigated the psychiatrists' views on a vignette of an elderly person with dementia. The questionnaire was in English, which is the official language of medicine in Egypt. The Cairo-based researchers collected the responses. The project was approved by the Cairo University ethical committee. Quantitative analysis of the data was performed using SPSS version 17 for Windows. All values of *P* were determined using the χ^2 -test.

Results

The questionnaire was sent to 195 psychiatrists; 160 responded (response rate 82%). Table 1 shows the demographic characteristics of the respondents and online Table DS1 summarises the responses to the questionnaire.

The majority of respondents (80%) were against physician-assisted suicide. On examining the effect of religion on the respondents' views, there was no difference between different religious affiliations (d.f. = 8, *P* = 0.278); however, respondents who were more adherent to their religious practices and those who described a higher influence of their religious beliefs on their medical practice were significantly more likely to oppose physician-assisted suicide (*P* = 0.01 and *P* = 0.02, respectively). There was no difference based on the respondents' gender (*P* = 0.585), age group (*P* = 0.542), grade (*P* = 0.695) or psychiatric specialty (*P* = 0.890). There was no difference between Christians and Muslims (*P* = 0.294) in believing that physician-assisted suicide was against their religious sentiments.

Clinicians were significantly more likely to agree with the concept of double effect than physician-assisted suicide (*P* < 0.001). The principle of double effect is a set of ethical criteria for evaluating the permissibility of acting when one's otherwise legitimate act (e.g. relieving a terminally ill patient's pain) will also cause an effect one would normally

Table 1 Characteristics of study participants (N = 160)

	n (%)
Gender	
Male	113 (70.6)
Female	47 (29.4)
Grade	
Trainee	72 (45)
Specialist	59 (36)
Consultant	17 (10.6)
Assistant professor	5 (3.1)
Professor	7 (4.4)
Age group, years	
<30	57 (35.6)
31–45	58 (36.3)
46–60	42 (26.3)
>60	3 (1.9)
Specialty	
General psychiatry	145 (90.6)
Forensic psychiatry	2 (1.3)
Addiction	6 (3.8)
Child psychiatry	7 (4.4)
Religion	
Muslim	134 (83.8)
Christian	22 (13.8)
Not disclosed	4 (2.5)
Religious adherence	
Strong believer	33 (20.6)
Believer; practises	102 (63.8)
Believer; rarely practises	8 (5)
Does not practise	3 (1.9)
Not a believer	6 (3.8)
Not disclosed	8 (5)
Religious influence	
Very strong	28 (17.5)
Strong	52 (32.5)
Some	60 (37.5)
Weak	8 (5)
None	12 (7.5)

be obliged to avoid (e.g. the patient's death). There was no difference in the views regarding double effect in terms of religious beliefs ($P=0.318$), age group ($P=0.753$), grade ($P=0.751$), gender ($P=0.741$) or specialty ($P=0.815$). Clinicians were significantly more accepting of withholding/withdrawing treatment than of physician-assisted suicide ($P<0.001$); there was no difference regarding gender ($P=0.531$), age group ($P=0.191$), religion ($P=0.072$) or specialty ($P=0.635$).

Psychiatrists were significantly better prepared to assess a patient who requested physician-assisted suicide (capacity assessment, mental health assessment) if they did not have to take part in the prescription of a lethal drug ($P<0.001$). There was no difference regarding gender ($P=0.871$), age group ($P=0.079$), religion ($P=0.486$) or specialty ($P=0.613$). Psychiatrists were more likely to agree to refer a terminally ill patient to another physician to consider physician-assisted suicide than to support physician-assisted suicide themselves ($P<0.001$).

The majority of respondents believed that physician-assisted suicide could be abused (82.4%) and that if it were legalised there would be an increase in requests for it (59.3%). The majority (66.3%) had never had a request or conflict regarding physician-assisted suicide, but 14.4%

described personal/internal conflict in considering this issue during their clinical practice, 6.3% described conflicts with their patients, 6.9% described conflicts with carers and 6.3% with other professions. When asked about how they would behave if physician-assisted suicide were to be legalised, the majority (51.9%) said they would rather resign from their jobs than take part; 8.1% said they would comply with the new regulations.

Regarding a clinical vignette describing an elderly man with dementia and terminal cancer (Section III of the questionnaire), opposition to physician-assisted suicide increased to 81.9% ($P<0.001$).

Discussion

It appears that although half of the general British population supports physician-assisted suicide,¹⁹ most British doctors in the UK are opposed to the legalisation of euthanasia and physician-assisted suicide.²⁰ However, another study,²¹ which surveyed 450 UK psychiatrists as a separate group, offered a different attitude: of the 322 psychiatrists who responded, 38% strongly agreed that physician-assisted suicide must be legalised in the UK and 64% strongly agreed that psychiatric assessment must be conducted in all cases. Some doctors support physician-assisted suicide for reasons of the pro-choice agenda.²² Some people caring for patients with dementia show support for passive euthanasia.²³ Despite the cultural differences between Egypt/Middle East and Britain, Egyptian psychiatrists' views, though stronger, were broadly similar to the views of UK doctors. The similarity also extends to views on the care of elderly people and palliative medicine: in our study, as in the UK survey,²⁰ dealing with terminally ill people and elderly patients, there was increased opposition to physician-assisted suicide. There are no clear indicators to establish whether the same split between the medical profession and the general public also exists in Egypt.

Despite attempts to reassure doctors that there would be a framework to protect vulnerable people²⁴ and support elderly people, psychiatrists remain concerned that legalising physician-assisted suicide could lead to abuse of the system, making the elderly and people with mental illness more vulnerable compared with the wider population,²⁵ especially in the light of comments such as those of Baroness Warnock.²⁶ In our study, the vast majority of Egyptian psychiatrists were concerned about the possibility of abuse of vulnerable people in society. The study also highlights the concerns regarding retention and employment of doctors should physician-assisted suicide become a legalised practice.

Our study shows that there are no significant differences in psychiatrists' views between Muslims and Christians in Egypt. This could indicate that Egyptian psychiatrists' views are influenced largely by culture rather than by religion. It will be useful to repeat the same study in the UK and in other parts of the world to understand the effect of doctors' cultural background on their views and beliefs regarding physician-assisted suicide.

Limitations of the study

This study, like all surveys, has limitations in terms of response bias. Moreover, this study covered only the views of Egyptian psychiatrists and did not consider other medical specialties or other allied medical professions or psychiatrists from other countries with different social and cultural makeup. Despite the similarity of views of Egyptian psychiatrists and British doctors, there is some doubt regarding the applicability of our findings to Britain and other parts of the world. It will be interesting and informative to repeat the same work in different countries and in different medical specialties.

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