Israeli Dying Patient Act
Physician Knowledge and Attitudes

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Objectives: The recently enacted Israeli Dying Patient Act was designed to strike balance between enhancing patient autonomy in end-of-life decision making and cultural/religious norms that are in opposition to active euthanasia and physician-assisted suicide (PAS). The current study evaluated physician attitudes regarding active and passive euthanasia, and their knowledge of specific aspects of the law.

Methods: A survey was administered to a convenience sample of hospital-based physicians treating terminal patients. Physicians were queried about their attitudes regarding euthanasia and PAS. Physicians were also queried about specific aspects of the law and whether they had sufficient resources to uphold the law.

Results: Surveys were distributed to 270 physicians and 100 were returned and evaluated (37%). Nearly all physicians supported passive euthanasia (withholding treatment), whereas over 40% maintained that active forms of euthanasia should be allowed for terminal patients in severe physical pain. Multivariate analysis showed a negative relationship between support for more active forms of euthanasia and physicians' self-reported religiosity. Physicians cited lack of time as a reason for not complying with the new law. Physicians had a familiarity with the general aspects of the new legislation, but a large proportion was not aware of the specifics of the law.

Conclusions: Compared with previous surveys, a larger number of physicians support passive euthanasia. A sizable percentage of physicians would be willing to participate in active euthanasia and even PAS. Attitudes toward euthanasia are influenced by religious factors.

Key Words: active euthanasia, end of life, passive euthanasia, physician-associated suicide

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Physicians have a role in maintaining their patients' lives and assisting them in the dying process. The means by which a physician intervenes in a patient's death may be passive or active. The course taken by a physician is governed by multiple factors including the medical condition, perceived desires of the patient or surrogates, the relationship with the patient, and the physician's own beliefs related to his or her role in the dying process.

To make end of life (EOL) decision-making more uniform and consistent, there has been a greater focus on EOL legislation that prescribes the types of interventions and the formal procedures involved in EOL care.[1,2] In most democratic and secular countries, specific legislation is the result of a pluralistic process that reflects cultural, religious, social, and ethical perspectives regarding the nature of life and death.[3–10] As is often the nature with the statutory process, final legislation represents compromise and accommodation.[11] EOL policies established by a national or state legislature may be opposed by a significant segment of physicians whose professional norms or personal beliefs regarding autonomy and beneficence may be at odds with laws limiting or permitting active interventions.

Passing EOL legislation has been particularly difficult in Israel because of the conflict between secular ethical trends stressing autonomy and Jewish religious dictums that prohibit most forms of active euthanasia.[12] Novel EOL legislation (Table 1) was enacted (Israeli Dying Patient Act [IDPA], 2005) to strike a balance between maximizing patient autonomy in EOL decision making while still being consistent with the dictates of religious practice.[13,14] A well-publicized aspect of the new statutes was allowing mechanical ventilators to be placed on timers so as to avoid difficulties associated with active euthanasia.[15]

In this study, we surveyed hospital-based physicians in Israel who have taken care of terminal patients to determine their attitudes regarding active and passive euthanasia and their understanding and awareness of the new legislation.

METHODS

The study was conducted at 2 teaching hospitals (Tel Aviv University Medical Center and Hadassah University Hospital) between 2008 and 2009. The study consisted of surveying a sample of physicians from different disciplines with experience caring for terminal patients. The survey was conducted among hospital-based physicians actively involved in the care of terminal patients. To select physicians most likely to be caring for terminal patients, physicians attending weekly medical rounds (oncology, surgical, and internal medicine) were provided with a hardcopy survey and given an explanation on how to fill out the questionnaire.

Survey Instrument

The 25-item survey contained 4 sections. The first section consisted of demographic questions pertaining to age, gender, specialty practice, years of practice, religious affiliation, and degree of religiosity. The survey recipient was asked whether he/she considered themselves religious (yes or no) and to rate the importance of religion in their lives on a 1 to 5 scale with 1 being religious practice is not important and 5 being religious practice is very important. In addition, physicians were queried regarding the number of seriously ill patients, terminal patients, and patients who died that they cared for during the

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TABLE 1. Israel's Dying Patient Act, 2005: Summary

1. A terminal patient (defined as expected life expectancy <6 mo) can refuse the initiation of life-prolonging treatments including mechanical ventilation
2. Active euthanasia or direct physician-assisted suicide is prohibited; continuous life-sustaining treatment cannot be terminated
3. Withholding nutrition and hydration is prohibited except for the final stages of life (last 2 wk) when a patient may refuse nutritional and fluid sustenance
4. Patients have the right to receive maximal pharmacologic analgesia even when treatment may shorten life
5. At the request of the patient or the patient's surrogate decision maker, life support can be discontinued if done in an indirect manner (eg, stopping a respirator with a timer)

preceding year. In the questionnaire, the phrase terminally ill was utilized without further definition as this was the subject of investigation in a later section. In the second section, physicians were asked about their attitudes toward passive euthanasia, active euthanasia, physician-assisted suicide (PAS), and terminal sedation for pain. The physicians were presented with a statement (eg, terminal patients have the right to forego life-sustaining treatment) and asked whether they agreed or disagreed with the position using a 5-point Likert scale with 1 being strongly disagreeing and 5 being strongly agreeing. In the next section, physicians were queried about their interactions with terminal patients. In the final section, physicians were asked questions to determine their knowledge of the IDPA. The questions ranged in level of difficulty regarding the definition of a terminal patient, the method for obtaining advanced directives, and conflict resolution between staff and family members. The survey instrument was pretested utilizing 10 health care professionals and corrected for problems of ambiguous language and other potential sources of bias.

TABLE 2. Physician Characteristics

Age (y)	41.3 ± 10.2
Gender (M:F)	1.38
Years in practice (mean ± SD)	12.1 ± 10.9
Distribution of physicians' years of practice (%)	
0-10	53.0
11-20	22.0
21-30	18.0
>30	7.0
Specialties (%)	
Internal medicine	45
Oncology	30
Surgery	23
Pediatrics	2
Estimated no. patients per physician with life-threatening illnesses in the past year (mean ± SD)	384 ± 585
Percent physicians with	
0-10 patients	3.1
11-100 patients	40.8
101-1000 patients	48.0
>1000 patients	8.2
No. patients per physician treated in the past year who were terminal (mean ± SD)	91.5 ± 148
Percent physician with	
0-10 patients	22.4
11-100 patients	58.2
101-1000 patients	19.4
Estimated no. patients per physician who died in the past year (mean ± SD)	50.4 ± 108
Percent physician with	
0-10 patients	31.0
11-100 patients	60.0
101-1000 patients	9.0
Considering oneself religious (%)	25.2
Importance of religion (1-5 scale with 5 being very important)	2.60
% of physicians for whom religion is important or very important	28.0

Statistical Methods

The data were entered into an Excel worksheet (Microsoft, Redmond) and transferred to commercial statistical software (SAS and SPSS). Frequency data (eg, number of patients treated, etc.) were converted to categorical variables to avoid skewing. For Likert-based opinion questions, the data were analyzed using parametric statistics and comparisons between items were made using the *t* test. Responses to Likert style questions were also dichotomized (agreeing and strongly agreeing as one group and all the other categories including disagree and having no opinion as a second group).

Principal component analysis was done as a method for classifying opinions regarding EOL treatment into different categories. Only factors with an Eigenvalue >1 were used (Kaiser criterion). Reliability analysis (Cronbach α) for all items in the section of the opinion questionnaire and for each factor group was also performed. Factor analysis of the positive response to specific survey items (opinions) pertaining to EOL legislation and practices was performed. On the basis of the analysis, respondents could be categorized into 2 categories dependent upon whether they supported only passive forms of euthanasia or if they also supported active euthanasia and PAS. The categorization of items listed in Table 3 is based on the analysis. The first category (items 1 to 4) dealt with more conservative interventions or legislation which are limited to passive or indirect euthanasia. The second category of opinions (items 5 to 10) consists of items associated with active interventions such as PAS.

Logistic regression was done for dichotomized data and linear regression analysis for continuous dependent variables. The analysis was done using both forced entry of demographic variables as well as both forward and backward addition or elimination. For forced entry, factors included in the analysis were those for which there was a high correlation in univariate analysis and consisted of age, sex, years in practice, number of terminal patients dying, and importance of religion. To address possible problems of multicollinearity, certain factors were not included in the analysis.

RESULTS

Surveys were distributed to 270 physicians involved in the care of terminal patients. One hundred surveys were filled out appropriately and evaluated (response rate: 37%). The demographic characteristics of the survey population are shown in Table 2. The majority of respondents were either internists or oncologists. Of the physicians surveyed, 25% considered themselves religious and 28% felt that religion was important or very important.

TABLE 3. Physician Attitudes Regarding Passive and Active Euthanasia*

	Mean ± SD (95% CI)	% Agreeing
Passive euthanasia		
1. Support right of terminal patient to refuse mechanical ventilation	4.66 ± 0.61 (4.54-4.78)	95.0
2. Support legislation allowing terminal patients to withhold nutritional support	3.91 ± 1.22 (3.67-4.15)	72.0
3. Right of terminal patient to refuse resuscitation is consistent with my personal and professional ethical principles	4.10 ± 1.28 (3.85-4.37)	78.0
4. Terminal patients should receive maximal analgesia even if it will hasten their death	4.57 ± 0.72 (4.42-4.71)	92.9
Active euthanasia and PAS		
5. The law should support PAS of terminal patients	2.66 ± 1.39 (2.38-2.94)	32.0
6. PAS should be permitted in patients with intractable pain	2.77 ± 1.39 (2.49-3.05)	42.0
7. PAS should be permitted in patients with severe psychological distress	2.25 ± 1.17 (2.02-2.48)	19.0
8. A law granting the right of a terminal patient to request PAS is consistent with my personal and professional ethical principles	3.00 ± 1.52 (2.70-3.30)	44.4
9. I would assist a patient wishing to end his/her life because of intractable physical pain if this were legal	2.92 ± 1.34 (2.65-3.19)	42.4
10. I would assist a patient wishing to end his/her life because of intractable psychological distress if this were legal	2.57 ± 1.33 (2.30-2.83)	28.3

*Opinions measured in a 1-5 Likert scale with 1 = strong disagreement and 5 = strong agreement.
CI indicates confidence interval; PAS, physician-assisted suicide.

Physicians surveyed had significant interactions with seriously ill and terminal patients. Over 50% of physicians dealt with between 10 and 100 patients who died from their illnesses. The average number of terminal patients treated per physician was 91.5 and for treated patients who died was 50.4. The difference between these numbers related to the fact that physicians caring for terminal patients did not always take care of them during the final stages (eg, radiation oncologists and surgeons).

Support for passive or indirect euthanasia was extremely high ranging from 72% to 95% (Table 3). Of note, item 4 which referred to providing maximal analgesia for pain even if it hastened death (double effect) was endorsed by 92.9% of respondents indicating support for this type of intervention even among those who generally only supported conservative EOL interventions.

Among the surveyed physicians, support for PAS (Table 3) was substantial but lower than that for passive euthanasia. Less than half the physicians surveyed supported legislation supporting active euthanasia or PAS or were morally in favor of such interventions. With regard to physical pain or psychological distress, 42% of the respondents thought that PAS should be permitted in patients with intractable pain (item 6) but only 19% would support PAS in cases of severe psychological distress (item 7).

The reliability (Cronbach α) for the entire questionnaire was 0.819. For the questions related to passive euthanasia and double effect, the reliability score was 0.543. The relative low score was partially related to the fact that the interitem correlation between items 2 and 3 (Table 3) was weak (0.103) indicating that those who endorsed legislation supporting passive euthanasia did not, on a personal basis, approve of passive forms of euthanasia and vice versa.

Both univariate and multivariate analyses were done to determine if any of the demographic, clinical, and religious characteristics of the physicians was related to support for more active interventions pertaining to the care of terminal patients. In terms of the 2 categories identified by factor analysis, support for active euthanasia and PAS interventions was related only to the importance of religion (Table 4). As shown in Table 4, the impact of religion was fairly consistent when items in Table 3 related to active euthanasia and PAS were analyzed individually. In all cases, the personal importance of religion was inversely related to support of active forms of euthanasia and PAS. No other variable including years of practice, number of terminal patients treated who

TABLE 4. Characteristics Associated With Support for Active Interventions*

	B	SE	β	*T*	*P*	
Support for active interventions (linear regression)†						
Religion important	−0.334	0.074	−0.433	−4.51	<0.001	
Logistic regression determining variables associated with support for PAS*						
Dependent variables	**Explanatory variables**	***B* (SE)**	**OR**	**95% CI**	***P***	**R^2**
Favor PAS legislation	Religion important	−0.41 (0.19)	0.66	0.46-0.96	0.028	0.11
Support for PAS	Religion important	−0.56 (0.18)	0.57	0.40-0.81	0.002	0.17
Support PAS for pain	Religion important	−0.68 (0.20)	0.51	0.35-0.75	0.001	0.23
	Patients dying/y	0.01 (0.01)	1.01	1.00-1.02	0.049	—
Support PAS for psychological distress	Religion important	−0.47 (0.23)	0.63	0.40-0.98	0.039	0.09

*Only significant variables in forced entry are reported.
†$R^2 = 0.20$.
CI indicates confidence interval; OR, odds ratio; PAS, physician-assisted suicide.

expired, or suffering a personal loss was significantly associated with those supporting active interventions with the exception that support of PAS for pain was modestly related to the number of dying patients per year treated by the physician (Table 4). With regard to whether physicians would participate in PAS (items 9 and 10), there was no relationship to level of religiosity or other factor.

Support for PAS for psychological distress—often termed existential pain—was significantly lower than that for physical pain (item 7 vs. item 6, $P < 0.001$ for either t test or Wilcoxon signed-rank test). Multivariate analysis was performed to determine which demographic or clinical characteristic was related to those willing to support PAS for physical pain and not for psychological distress. Those for whom religion was important did not perceive any difference between the 2 categories of PAS and were opposed to both. In contrast, physicians for whom religion was not important often made a distinction between the 2 and were supportive of PAS for physical pain but not psychological distress.

Physicians were surveyed to determine whether there was sufficient time to discuss EOL issues and whether this was part of their role as a physician (Table 5). Most physicians felt that it was their role to discuss EOL issues with patients including advanced care directives (item 15), set aside time to speak to them (item 14), and felt comfortable doing so (item 13). Simultaneously, few physicians believed (13.1%) that most patients were aware of the legal options available to them regarding EOL decision making (item 11). Likewise, only 12% of the physicians believed that there was adequate time given to discuss EOL issues (item 12).

The final section of the survey dealt with physician awareness of the law (Table 6). Physicians were aware of the basic foundations of the law such as the ban on PAS (question 4) and the appropriateness of giving maximal analgesia even at the expense of hastening death (question 6). When it came to specifics such as the criteria for being defined as a terminal patient, a majority of physicians answered incorrectly (questions 1 and 2). In general, better scores on the test were not related to experience treating critical or dying patients. The only exception was the right of a patient to choose a treatment that a physician considers inappropriate (question 7). In this case, the number of patients treated by a physician who subsequently died was related to an incorrect response (OR, 0.995; 95% CI, 0.992-0.999; $R^2 = 0.144$; $P = 0.011$).

DISCUSSION

The Israeli legislature ratified the Dying Patient Act in 2005 which established guidelines for the treatment of terminal patients. Although the legislation is circumscribed to a limited set of patients who fit the definition of terminal according to the law (Table 1), the types of interventions allowed by the law were extensive and provided legitimacy for passive euthanasia by patient request and aggressive pain management even when shortening of life ensues. The law provided a mechanism by which life support such as mechanical ventilation could be discontinued in an active but indirect manner such as placing respirators on timers.

The question arises as to whether such legislation would be widely accepted by physicians who treat terminal patients. For there to be compliance with a law, three components are necessary. Physicians must be aware of the specifics of the law. They have to agree with the spirit of the law, and if not, defer to the law even when it is in opposition to personal beliefs. Finally, resources must be available to implement the law.

In terms of knowledge of the IDPA, physicians were not aware of many of the detailed aspects of the law (eg, specific

TABLE 6. Knowledge Regarding Israel's Dying Patient Act, 2005

	% Correct Answers
Legal definition and rights of terminal patients	
1. Expected life expectancy	28
2. Age which individual is competent for making EOL decisions	35
3. Validity and primacy of advanced medical directives	17
Legally appropriate EOL interventions	
4. Physician-assisted suicide (prescribing lethal medications)	97
5. Acquiescing to patient's request to stop sustenance because of severe pain	48
6. Prescribing high doses of analgesic for pain even if it will unintentionally hasten death (double effect)	80
7. Right of terminal patient to choose life-prolonging treatments that the physician considers inappropriate	84
Decision-making mechanisms and EOL interventions	
8. Responsibility of physician with regard to advanced medical directives	26
9. When it is appropriate to convene an institutional ethics committee	78
10. Appropriate mechanisms for resolving conflicts between medical staff and/or family members	77

EOL indicates end of life.

TABLE 5. Physician Interactions With Terminal Patients*

	Mean ± SD (95% CI)	% Agreeing
11. The majority of my patients are aware of the legal options available to them including advanced life directives regarding terminal care	2.41 ± 0.88 (2.24-2.59)	13.1
12. Within the medical framework, there is adequate time to discuss treatment options with terminal patients	2.04 ± 0.99 (1.84-2.24)	12.1
13. I feel comfortable discussing initiation or termination of treatment with terminal patients or their families	3.74 ± 1.03 (3.54-3.95)	70.4
14. In the context of treating terminal patients, I set aside time to speak to patients with terminal illnesses	3.67 ± 1.05 (3.46-3.88)	65.6
15. It is not the role of a physician to discuss advanced care directives with patients	1.54 ± 0.79 (1.38-1.70)	4.1

*Opinions measured in a 1-5 Likert scale with 1 = strong disagreement and 5 = strong agreement; numbering of items is a continuation from Table 3
CI indicates confidence interval.

definition of a terminal patient and procedural aspects for obtaining informed consent) even though they were cognizant of the spirit of the law regarding passive euthanasia, pain management, and PAS. The lack of awareness of the specifics of the legislation may be related to the fact that many EOL discussions are handled by nonphysician support staff (eg, social workers) even though the responsibility for decision making is assigned to the physician by law. However, the fact that many physicians are not aware of the exact definition of a terminal patient (Table 6, question 1) raises the possibility that physicians, from either lack of awareness or disagreement, are not complying with the law.

With regard to agreement with the law, most physicians, irrespective of religious background and religiosity, supported the legislation and felt that it was consistent with their personal beliefs. An overwhelming majority of physicians agreed with the right of the patient to forego life-sustaining treatment and to receive maximal analgesia. However, a substantial minority of physicians supported PAS especially in situations of intractable pain and would be willing to participate in PAS procedures if they were legalized.

The relationship between EOL decision making, religious affiliation, and religiosity has been shown in several studies.[16–20] In a large-scale observational study of European and Israeli ICU patients, an association between religious affiliation and EOL decision making was found with Jewish, Greek Orthodox, and Muslim physicians being more likely to withhold (passive euthanasia) rather than withdraw treatment.[19] In comparative studies conducted in countries in which religion is a more pervasive part of the culture, there was a more conservative attitude regarding euthanasia, PAS, and terminal sedation.[16,19] Cohen et al,[20] representing the European End-of-Life Care Research Group, surveyed physicians from 6 countries and found that religious and philosophical life stances influenced physician attitudes and practices. Similar to our findings, life stances associated with specific religious affiliations had the greatest impact with regard to issues such as PAS. There was less of an impact on nontreatment decisions and pain treatment associated with potential shortening of life as there was a general consensus with regard to these interventions. However, similar to the study by Sprung et al,[19] there were differences in attitudes among physicians from different countries that were unrelated to religious or other life stances suggesting national cultural influences also had an impact. In our study, we found that not only is the religious environment determinant, but also the importance of religion for the individual (religiosity). These findings parallel those of Wenger and Carmel[21] who surveyed Israeli physicians over a decade ago and identified a similar relationship.

Willingness to participate in PAS if it were allowed by law was not related to religiosity (items 9 and 10). In this case, the degree of religiosity was not an associated factor even though it was a factor with regard to the physician's attitudes toward PAS. This discrepancy could indicate that physicians are willing to suppress their own personal feelings which are often based on the degree of their religiosity in favor of patient autonomy and legislative support for such actions. Dickinson and colleagues, in a meta-analysis of US physicians assessing attitudes toward PAS, noted a similar discrepancy between willingness to participate in PAS and supporting legislation. They felt that the reason why physicians did not "practice what they preached' was rooted in their respect for patient autonomy.[22]

The overwhelming support for maximal pain remediation even if it shortens life (double effect) was surprising. First, the issue of double effect remains controversial for both Jewish ethicists and Rabbinical authorities.[23,24] Second, the concept of double effect is often utilized to justify terminal sedation which is considered by many ethicists to be a form of active euthanasia. As noted by Jansen and others, the concept of double effect is often subjective so that even though the same action is being performed, one physician's goal is to alleviate pain whereas another physician may be using this as a rationale for PAS.[25–28]

There are several limitations to the study. First, the sample was restricted to hospital-based physicians, and it is possible that the attitude of the general physician population is different. However, by selecting hospital physicians participating in medical rounds, we chose a population that was more likely to deal directly with EOL issues and be involved in EOL decision making.

A second limitation is that for the opinion questions, we did not quantify the term terminal in terms of life expectancy so that it is quite likely that the respondents had different concepts of terminality. However, we were hesitant to strictly define terminal as defined by the IDPA (6 mo life expectancy) as this would have biased questions related to knowledge of the law. Defining terminality as a predicted life expectancy of $\leq$6 months is subjective both in terms of the selection of the criterion and physicians' assessment of specific patients.

In conclusion, the current study shows that while there is strong support for passive euthanasia upon which the IDPA is based, a significant proportion do not support PAS. However, the distinction between active and passive forms of euthanasia is becoming blurred with physicians willing to provide pain medications at a dose that will hasten death and methods of terminating life support in an active but indirect manner.

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